Massage Therapy Case History Form

Patient Name: _____ Gender: Male Female Date of Birth: _____

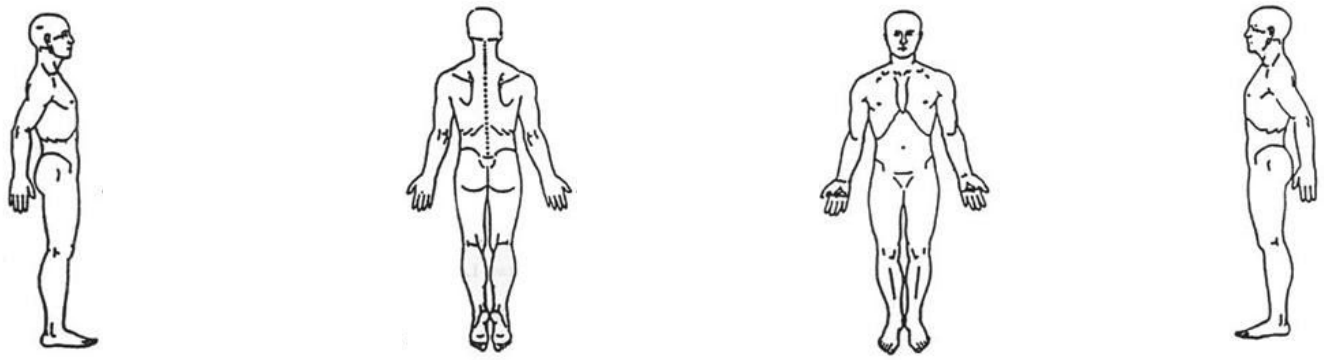
Address: _____ Occupation: _____

Phone: (Home) _____ (Work) _____ (Mobile) _____ (Email) _____

Are you in a Health Fund? _____ If yes, which one? _____ Previous Massage? _____

What is the main reason for your visit? _____

Please locate on the diagrams below: X for pain; O for stiffness; N for numbness



Please rate the pain on a scale of 0 (no pain) to 10 (extreme pain): _____

Any allergies? YES NO If so, what? _____

Any contact lenses, prosthetic devices, dentures or pacemaker? YES NO Any chance of you being pregnant? YES NO

Are you currently seeing a medical doctor, chiropractor, osteopath or any other health care practitioner? YES NO

Ifso, for what condition(s)? _____

Taking any medication? YES NO What for? _____

Whilst massage therapy is very beneficial, it may sometimes not be appropriate, or it may need to be modified to best suit your needs and state of health. Please circle Yes or No to all the listed conditions listed below and if you currently have or had any of the following in the past, please provide details under Comments below:

		Comments			Comments
Headache	Y N		Indigestion	Y N	
Head Injury/Concussion	Y N		Nausea/Vomiting	Y N	
Seizures	Y N		Diarrhoea	Y N	
Vision Disturbance	Y N		Varicose Veins	Y N	
Ear Infection/Pain	Y N		Malnutrition/Weight Loss	Y N	
Inflammation	Y N		Infectious Diseases	Y N	
Any form of cancer	Y N		Skin Condition	Y N	
Chest Pain	Y N		Fracture(s)	Y N	
Breathing Problems	Y N		Diabetes	Y N	
Asthma	Y N		Sprain/bruises	Y N	
Tuberculosis	Y N		Fever	Y N	
Heart Problems	Y N		Tetanus	Y N	
High Blood Pressure	Y N		Any undiagnosed pain	Y N	
Back Pain	Y N		Past/Scheduled Surgery	Y N	
Should/Hip/Knee Pain	Y N		Other	Y N	

I, (PRINT NAME) _____ declare that all the answers and statements above are true and complete. I have stated all my known medical conditions and take it upon myself to keep the Massage Therapist updated on my health during any subsequent treatments.

There is a missed appointment fee equal to your consultation fee for any missed or cancelled appointments with less than 24 hours' notice.

Client signature: _____ Date: _____

Therapist signature:_____ Date:_____