# MASSAGE THERAPY
# CONFIDENTIAL PATIENT HISTORY FORM

| | | | |
|---|---|---|---|
| Name | | Occupation | |
| Address | | Physician | |
| City | | Referring | |
| Province | | Professional | |
| Postal Code | | Birth Date | |
| Home No. | | | (Month/Day/Year) |
| Mobile No. | | Insurance Co. | |
| Email | | | |

How did you hear about our therapist? _____

How did you hear about our clinic? _____

Have you received massage therpay before? YES ☐ NO ☐

If yes, what was the date of your last visit? _____

**PLEASE INDICATE CONDITIONS YOU ARE EXPERIENCING OR HAVE EXPERIENCED**

**CARDIOVASCULAR**

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Stroke
- ☐ Pacemaker
- ☐ Varicose Veins

**RESPIRATORY**

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Smoking

**HEAD/NECK**

- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Ear Problems
- ☐ Hearing Loss
- ☐ Headaches

**INFECTIONS**

- ☐ Hepatitis
- ☐ TB
- ☐ HIV
- ☐ Plantar Warts

**WOMEN**

- ☐ Menstrual Problems
- ☐ Menopausal
- ☐ Children
  No. of Children _____
- ☐ Pregnant
  Due Date: _____

**SKIN**

- ☐ Skin Conditions
- ☐ Skin Irritations
- ☐ Bruise Easily

**OTHER CONDITIONS**

- ☐ Loss of Sensation
- ☐ Diabetes
- ☐ Allergies
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis

Please list any medication which you are presently taking: _____

_____

# CURRENT CONDITION

Please describe your current condition and symptoms.

_____

_____

_____

How long have you had this condition?

_____

How did it start?

_____

_____

What aggravates it?

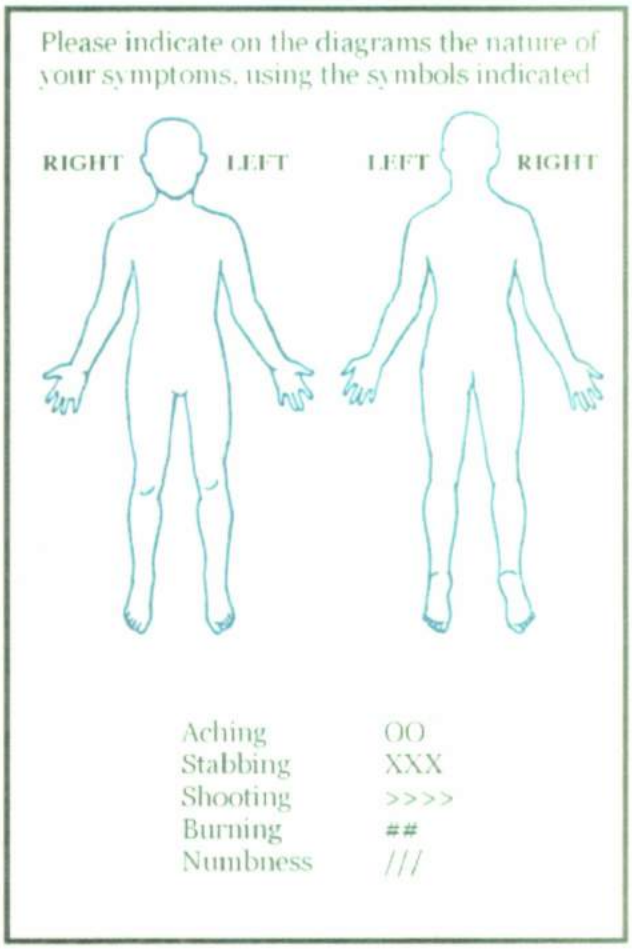
_____

_____

What relieves it?

_____

_____




Are you currently under another treatment plan with any of the following practitioners?

| | | Date of Last Visit |
|---|---|---|
| ☐ | Massage Therapist | _____ |
| ☐ | Chiropractor | _____ |
| ☐ | Physiotherapist | _____ |
| ☐ | Naturopath | _____ |
| ☐ | Acupuncture | _____ |
| ☐ | Other | _____ |

# NOTES

_____

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