Massage Therapy Case History Form

Personal Information

Name_________________________________ Date of Birth_______________________
Address
____
City___________________________________ Postal Code_______________________
Home Phone#__________________________Work Phone#______________________
Occupation____
Emergency Contact Person____
Referred to Office By?____
Hobbies or Activities____
Do you have a regular Exercise Schedule?
Explain________________________________
____

Current Health Condition

Family Physician_____________________________Ph#______________________________
Are you on any Medications? Please name____
____
____
Do you have any Allergies? Please
name____
____
Are you Pregnant?_____________Due Date______________Weeks Pregnant_______________
Are you wearing any contact lenses?
____

Have you ever been involved in an accident? (i.e. Motor vehicle)
____
Please explain____
Have you had any surgeries, sprains/strains, or fractures with in the past year?
____
Please explain____
Do you have/had cancer, diabetes, high blood pressure, vascular disease or any arthritic
conditions?____
____
Is there any other medical condition I should be aware of?_______________________________
____
Have you had a professional Massage?
____
Likes or Dislikes?
____

Treatment Information

Areas of discomfort____
How long have you had this discomfort?
____
Cause of discomfort?
____
What type of pain is it? (Please check all that apply)
☐ Stabbing ☐ Throbbing ☐ Sharp ☐ Aching ☐ Shooting ☐ Burning ☐ Weak
☐ Numb ☐ Tingling ☐ Nagging ☐ Cramping

Treatment Information Con't

Does the Pain travel or radiate? ____

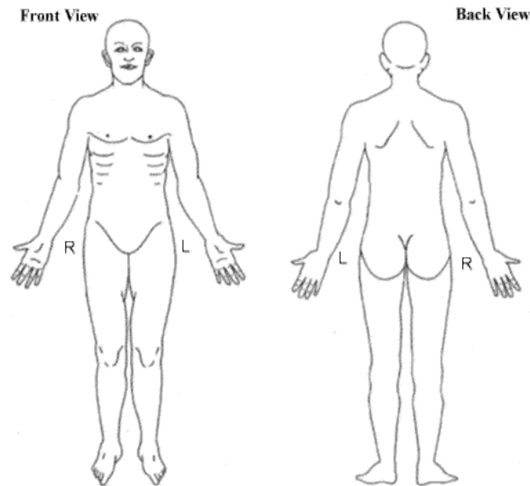
What makes it worse?____
What makes it better?____
Have you been treated for this complaint by any other Professional? ___________________

- [ ] Doctor ____
- [ ] Massage Therapist____
- [ ] Chiropractor____
- [ ] Physiotherapist____
- [ ] Other____

Are you sleeping well at night? ____

What are you expectations from this treatment today?______________________________
____

Please circle/shade/mark in the areas where you are feeling the pain:



I understand that Massage Therapy is not a substitute for medical examinations or diagnosis. I understand that a Massage Therapist does not diagnose illness, disease, and mental disorders or perform any spinal adjustments. Massage Therapy is contraindicated with certain medical conditions and with some medications. By signing this form, I agree that all information is correct and complete. Please inform the Therapist if anything being done makes you feel uncomfortable. Feel free to ask questions before, after and during the treatment. It is my responsibility to keep the Massage Therapist informed and updated on any changing conditions.

Billing for a missed appointment will take place unless 24 hour is given to cancel. Payment for treatment is due upon completion of treatment.

Signature____________________________________Date_________________________
E-Mail Address (for appointment reminders only):________________________________