Rutherford MASSAGE THERAPY CLINIC

Medical History Form

The reasons for obtaining this information are:
a) this is a College of Massage Therapists requirement
b) to enable the therapist to individualize treatment
c) to help identify other possible conditions
d) to alert the therapist to conditions for which certain massage therapy modalities are contraindicated

Name: _____ Date: _____

Address: _____ Birth Date: _____

City: _____ Postal Code: _____

Phone: Home: _____ Type of Work: _____

Business: _____ Weekly Work Hours: _____

Email: _____ (for Online Booking)

Primary Health Care Professional Name: _____ Phone: _____

Primary Health Care Professional Address: _____

May we contact her/him? ____ Yes ____ No Last Appointment: _____

Who referred you to this Clinic/How did you hear about us? _____

Your reasons for attending this Clinic: _____ Work-related injury? ___ Yes ____No

Describe your **general health** status:_____

Muscles / Joints:
____ tension headache / migraine
____ history of tension headaches
____ history of migraines
____ whiplash
____ head trauma / concussion
____ loss of co-ordination
____ neck stiffness / pain / injury
____ tooth / jaw / ear pain
____ shoulder stiffness / pain
____ arm pain / weakness / tingling
____ back pain / injury
____ sciatica / hip pain / buttock pain
____ scoliosis
____ knee pain
____ leg pain / weakness / tingling
____ foot or ankle pain
____ strain / sprain
____ tendonitis / bursitis
____ fractures: _____
____ pins / wires /special equipment
____ family history of osteoarthritis

Nerves:
____ vision loss
____ hearing loss
____ loss of sensation
____ nervousness / anxiety
____ loss of sleep
____ nerve pain

Skin:
____ open sores / cuts/ warts
____ rashes / athlete's foot
____ sensitive skin / hives
____ heat / cold sensitivities

Lifestyle Questions:
____ exercise regularly
____ poor energy levels
____ poor sleeping patterns
____ smoke

Heart / Circulation:
____ heart disease
____ history of heart attack
____ history of stroke
____ chronic congestive heart failure
____ family history of cardiovascular difficulties
____ high blood pressure
____ low blood pressure
____ phlebitis / varicose veins
____ hardening of the arteries
____ chest pain / angina
____ rapid heartbeats
____ cold hands & feet
____ swelling
____ light headed / fatigue
____ poor healing
____ anemia
____ bruise easily / hemophilia
____ presence of pacemaker or similar device

Lungs / Respiration:
____ asthma
____ bronchitis
____ emphysema
____ family history of respiratory difficulties
____ allergies:
_____ environmental
_____ nuts
_____ other: _____
____ hypersensitivity reaction
____ anaphylactic response
____ chronic cough
____ nasal obstruction
____ shortness of breath

Women:
____ are you pregnant?
due date: _____
____ gynaecological conditions

Digestion:
____ unusual loss / gain weight
____ diarrhea / constipation
____ abdominal pain

Infectious Conditions:
____ skin conditions
____ respiratory conditions
____ hepatitis
____ HIV
____ herpes
____ tuberculosis
____ other: _____

Other Diagnosed Diseases or Medical Conditions:
____ digestive e.g. colitis, IBS
ulcers: _____
____ diabetes
____ jaundice / hepatitis
____ liver or gall bladder problems
____ hernia
____ urinary: _____
____ mental illness
____ depression
____ degenerating discs
____ osteoarthritis
____ rheumatoid arthritis
____ osteoporosis
____ scoliosis
____ muscle disease
____ bone disease
____ fibromyalgia / chronic fatigue
____ multiple sclerosis
____ epilepsy
____ neurological disorders

Cancer:
____ recent diagnosis
____ undergoing treatment
____ remission
____ type: _____

Name:

Date:

Have you received Massage Therapy before? ____ Yes ____ No If so, how often? _____

For what reasons? _____

Are you currently involved in treatment with other Health Care Professionals? (i.e. Chiropractor, Physiotherapist, Naturopath,

Osteopath, Specialist, etc) ____ Yes ____ No If yes, who? _____

For what reason? _____

Medications / Conditions:
Please list all current and/or regular medications, including aspirin or other over-the-counter pharmaceuticals/supplements:

Medication	Condition used for:

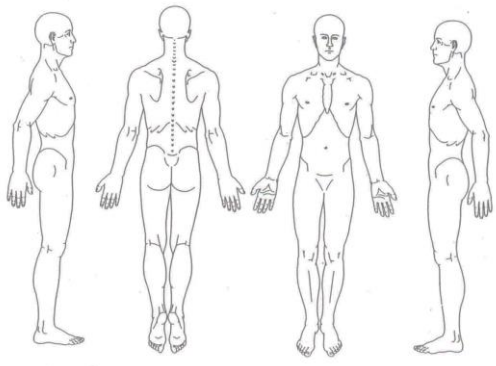
Injury / Accident History:
Please list major injuries or prior car accidents, including approximate date, areas affected and treatment received (i.e. Physiotherapy, Chiropractic, Massage Therapy):

Date	Type of Injury / Area Affected	Treatment Received

Surgery:
Please list all past surgeries, including approximate date:

Date	Surgery

Indicate on diagram areas of pain, joint and muscle stiffness, tingling and or numbness:
Primary complaint: _____



Consent:
I understand that Massage Therapy involves manipulating the soft tissues and joints of the upper body in order to rehabilitate, improve function, and enhance well-being. The position of the body and the draping used are designed to provide comfort and warmth. The likely risks and benefits of my treatment have been explained to me and I understand that I am free to make inquiries or request modifications in any aspect of my session at any time (i.e. position, depth of pressure, draping). The therapists at Rutherford Massage Therapy Clinic work collectively; therefore, my health information may be communicated within the clinic as needed. I am free to specify confidentiality to one therapist if I so desire.

I understand the information given on this form is absolutely confidential, and will only be released to other Health Care Professionals or Legal Representatives with my written consent or as dictated by the Massage Therapy Act, Health Care Consent Act, the Regulated Health Professions Act and the Personal Health Information Protection Act.

I understand a notice of 12 hours is required for cancellation or to reschedule my appointment, or a fee will be charged.

Date: _____ Signature: _____