CONFIDENTIAL CASE HISTORY AND INTAKE FORM

Registered Massage Therapist - Massage Therapy Treatment

An accurate health history is important to ensure that it is safe for you to receive massage therapy treatment. The CMTO requires that this history be updated on a yearly basis at a minimum. Please inform your massage therapist immediately of any and all health status changes in the future. All information is confidential except as required or allowed by law or to facilitate assessment of treatment.

NAME: _____ ADDRESS: _____

DATE OF BIRTH: _____ (dd/mm/yyyy) _____

DAY PHONE: _____ CITY: _____

CELL PHONE: _____ POSTAL CODE: _____

OCCUPATION: _____ EMAIL: _____

FAMILY PHYSICIAN: _____ PHYSICIAN ADDRESS: _____

PHYSICIAN PHONE: _____ _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE: _____

CURRENT MEDICATIONS/
CONDITIONS TREATED: _____

ALLERGIES: (PLEASE LIST ALL) _____

Are you currently being treated by another health care provider? YES NO *If yes, name of provider/service:* _____

Have you received massage therapy treatment before? YES NO *If yes, date of last treatment:* _____

Source of referral: (practitioner, friend, website etc.) _____

CHIEF COMPLAINT: _____ TYPE OF PAIN: _____

_____ DOES IT RADIATE? YES NO

_____ IF SO, WHERE? _____

WHAT RELIEVES THE PAIN/CONDITION? _____

WHAT AGGRAVATES THE PAIN/CONDITION? _____

OTHER THERAPIES CURRENTLY USING? _____

PLEASE DESCRIBE & DATE PAST SURGERIES _____

AND/ OR INJURIES YOU HAVE SUFFERED: _____

_____

MOTOR VEHICLE ACCIDENT? YES NO OVERALL, HOW IS YOUR GENERAL HEALTH? _____

ARE YOU PREGNANT? YES NO IF YES, HAVE YOU BEEN SEEN BY YOUR FAMILY PHYSICIAN/MIDWIFE? YES NO

IF YES, DUE DATE: _____ ANY GYNAECOLOGICAL CONDITIONS? _____

OF PREGNANCIES: _____ ANY CURRENT PREGNANCY CONCERNS? _____

OF CHILDREN: _____ PAST PREGNANCY COMPLICATIONS? _____

HEALTH HISTORY - Please check or circle all conditions that apply:

MUSCLES/JOINTS/NERVES

- ☐ Swelling
- ☐ Limitation of Movement/ROM
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Pain/Stiffness/Injury Location
  Location:_____
- ☐ Multiple Sclerosis
- ☐ Degenerative Disc Disease
  C/T/L Spine Level
- ☐ Spasm/Strain Sprain
  Location:_____
- ☐ Tendonitis/Bursitis
- ☐ Fractures/Pins/Wires/Plates
  Location:_____
- ☐ Artificial Joints
  Location:_____
- ☐ Sports/Work Related Injuries
- ☐ Repetitive Strain Injury
- ☐ Carpal Tunnel Syndrome
  L/R Wrist
- ☐ Osteoarthritis/Rheumatoid Arthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Other:
- ☐ Family history of any of the above
- ☐ Details:

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ Above Medically Controlled
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Congestive Heart Failure
- ☐ Varicose Veins/Phlebitis
- ☐ Blood Clot
- ☐ Dizziness
- ☐ Chest Pain/Angina
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Stroke
- ☐ Other:

HEAD/NECK

- ☐ Headache - Tension/Migraine
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Ear/Jaw/Tooth Pain
- ☐ Head Trauma/Concussion
- ☐ Allergies
- ☐ Neck Pain/Stiffness/Injury
- ☐ Other:

RESPIRATORY

- ☐ Chronic Cough
- ☐ Congestion
- ☐ Asthma or Bronchitis
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Other:
- ☐ Family history of the above
- ☐ Details:

DIGESTIVE

- ☐ Poor/Excessive Appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Gas
- ☐ Liver/Gallbladder
- ☐ Ulcer
- ☐ Alcohol Consumption
- ☐ Celiac/Chrohn's/Colitis
- ☐ Other:

ADDITIONAL CONDITIONS/NOTES

_____

_____

_____

SKIN

- ☐ Sensitive skin
- ☐ Rashes/Conditions
- ☐ Eczema
- ☐ Cold sores
- ☐ Contagious Conditions
- ☐ Sensitivity to Lotion/Oil
- ☐ Bruise easily
- ☐ Other:

OTHER CONDITIONS

- ☐ Cancer
- ☐ Epilepsy/Seizures
- ☐ Hepatitis
- ☐ HIV
- ☐ Hemophilia
- ☐ Lupus
- ☐ Diabetes
- ☐ Mental Illness
- ☐ Other:
- ☐ Family history of the above
- ☐ Details:

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For any missed or cancelled appointments with less than 24 hours notice there will be a $50.00 fee payable at your next visit. Due to the high patient volume within the clinic, if given 24 hours notice it will allow the staff time to contact patients on the waiting list to fill your appointment time. Your consideration and cooperation is most appreciated.

Release of Personal Information

I hereby fully authorize my RMT , Registered Massage Therapist to exchange medical and/or other information necessary with other medical professionals handling my case, WSIB (if applicable), and/or my motor vehicle auto insurance company (if applicable) and any third party payers and benefit plan insurance companies (if applicable).

I understand that this information will be used to provide me with the most individualized and optimal massage therapy treatment care and will be kept strictly confidential.

Consent for Treatment

I hereby offer my consent to participate in massage therapy treatment, which I have been told may include pain control modalities, exercise prescription, manual therapy of muscle, joint and soft tissue, passive muscle stretching, and health care education and teaching. I also give my consent to have communications made from the clinic or my RMT, Registered Massage Therapist to be sent via phone, mail, email or text message, or any other reasonable form of communication that the clinic may utilize.

I understand that I may withdraw my consent for treatment at any time, for any reason, without penalty.

☐ I HAVE READ, UNDERSTOOD AND ACKNOWLEDGED THE PRIVACY POLICY OF THIS CLINIC AND MASSAGE THERAPY PRACTICE. I ALSO ACKNOWLEDGE THAT ALL OF THE INFORMATION THAT I HAVE PROVIDED IS TRUE TO THE BEST OF MY KNOWLEDGE AND THE MOST CURRENT MEDICAL INFORMATION HAS BEEN PROVIDED.

Signed Consent (Patient) _____ Date (dd/mm/yyyy) _____

Please read the following and acknowledge:

I have been informed of and have understood the reason(s), if indicated, for receiving massage to to following areas:

- Buttock(s) (gluteal muscles)
- Inner Thigh(s) (groin muscles)
- Chest Wall Muscles
- Breast Tissue (Standards of Practice Technique 13)

I have had all of my questions regarding sensitive area treatment answered by my RMT , Registered Massage Therapist. I understand and acknowledge that I have received sufficient information regarding the nature of a treatment plan that would include treatment to sensitive areas of the body, the reasons, the benefits, risks, side effects and proposed draping (covering) of such areas and will be asked for verbal consent with each treatment of any of these areas. I understand that I may change my mind, alter, rescind or refuse treatment at any time during this or any other treatment. This signed and completed form will be kept secure in my client file.

Signed Consent (Patient) _____ Date (dd/mm/yyyy) _____

Registered Massage Therapist Signature _____ Date (dd/mm/yyyy) _____

Updated March 2017