

WATERLOO SPORTS MEDICINE CENTRE

Massage Therapy Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone Number: _____

Address: _____

Occupation: _____ Date of Birth: _____

Have you received massage therapy before? Yes No

Did a health care practitioner refer you for massage therapy? Yes No

If yes, please provide their name and address: _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
 high blood pressure
 low blood pressure
 chronic congestive heart failure
 heart attack
 phlebitis / varicose veins
 stroke / CVA
 pacemaker or similar device
 heart disease

Respiratory
 chronic cough
 shortness of breath
 bronchitis
 asthma
 emphysema

Is there a family history of any of the above? Yes No

Infections
 hepatitis
 skin conditions
 TB
 HIV
 herpes

Other Conditions:
 loss of sensation, where? _____

diabetes, onset: _____
 allergies / hypersensitivity to what? _____
 type of reaction: _____
 epilepsy
 cancer, where? _____
 skin conditions, what? _____

arthritis
 is there a history of arthritis?
 Yes No

Head/Neck
 history of headaches
 history of migraines
 vision problems
 vision loss
 ear problem
 hearing loss

Women
 pregnant, due: _____
 gynecological conditions, what? _____

Overall, how is your general health?

Primary Care Physician:
 Name: _____
 Address: _____

Current Medications: _____

Condition it treats: _____

Are you currently receiving treatment from another health care professional? Yes No
 If yes, for what? _____

Surgery – date: _____
 Nature: _____

Injury – date: _____
 Nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness)
 Yes No
 what? _____

Do you have any internal pins, wires, artificial joints or special equipment? Yes No
 What? _____
 Where? _____

What is the reason you are seeking massage therapy?
 Please include the location of any tissue or joint discomfort.

Notes:

Date of Initial Health History: _____
 Update 1: _____
 Update 2: _____
 Update 3: _____
 Update 4: _____

Treatment Plan for: _____ Date: _____

Limitations of activities of daily living:

Treatment plan discussed with Client:

Yes No

Client's Goal / Treatment Goal:

Received informed consent for treatment plan:

Yes No

Type / Focus of Treatment:

Frequency: _____

Duration: _____

Areas to be treated:

Back arms L R

Chest

Neck leg L R

Breast

Shoulders gluteus

Other (list)

Face abdominals

Assessments Performed:

Anticipated Progression of Responses:

Result of Assessments:

Remedial exercises / Hydrotherapy

Reassessment schedule:

Contraindications / Risks:

Referrals:

