MASSAGE THERAPY CASE HISTORY FORM

The information on this form is confidential and will be used for no other purpose than to ensure proper treatment. Please inform us of any changes in the future.

Name: _____ Date: _____
Date of Birth (D/M/Y): _____ Telephone (H): _____ (W): _____
Address: _____ Postal Code: _____
Email Address: _____
Emergency Contact (Name): _____ (Phone): _____
Your Occupation and Related Duties: _____
Do you have a sport or recreational activity? : _____
How did you hear about this clinic? : _____
What brings you in for a massage? : Injury Treatment / Relaxation / Other _____
Have you had a professional massage before? For what condition? : _____
Date of last massage: _____ Have you received any other treatment for this injury? Yes / No (if so, please describe) _____
Are you seeking treatment as a result of a Motor Vehicle Accident? : Yes / No
Date of accident: _____ Medical Doctor: _____

Medical and Treatment Information

Describe your injuries/condition and your current symptoms: _____
_____
_____
Have you ever had surgery? Yes / No Date: _____ Please describe :
_____
_____
Do you have any artificial limbs, pins, screws, hearing aids, etc. : _____
Are you currently taking any medications or supplements? : _____
Are you pregnant? : Yes / No Due date: _____
Do you have a history of/or are you currently experiencing any of the following (please check):
___Migraines ___Headaches ___Dizziness ___Ringing in Ears ___Jaw Pain ___Heart Condition
___Sinus Infections ___Blurred Vision ___High/Low Blood Pressure ___Arthritis ___Stroke
___ Rheumatoid/Osteoarthritis ___HIV ___Diabetes ___Varicose Veins ___Phlebitis
Cancer (type): _____ Skin Conditions: _____
Allergies: _____ Joint Pain: _____
Tingling/Numbness: _____
Gastro Intestinal Conditions: _____
Kidney/Bladder Conditions: _____
Respiratory Conditions: _____
Other: _____

Please describe any other significant injuries, traumas or accidents (include year and treatment): ___

_____

_____

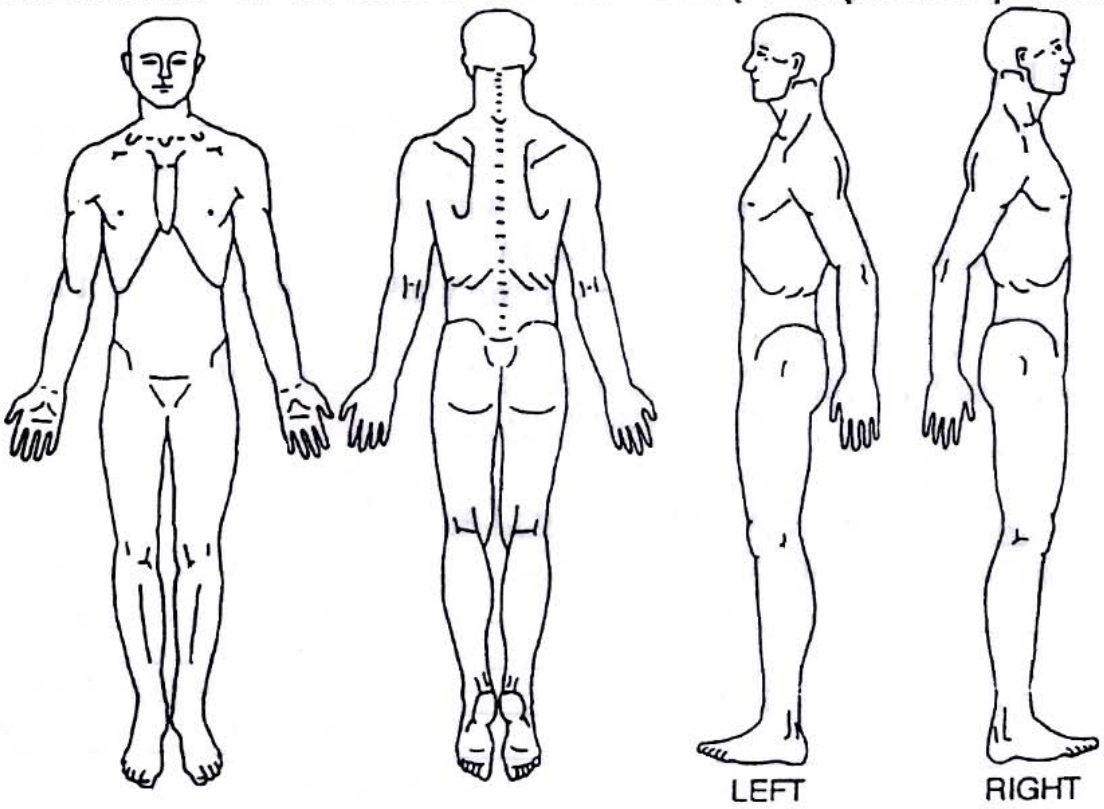
_____

_____

_____

_____

Please make an "X" or circle over areas where you experience pain or discomfort



Please read carefully and sign.

With regard to any cancellation of scheduled appointments, we require at least 24 hours notice or a fee of 50% of the appointment cost will be charged. Extenuating circumstances will be reviewed. Furthermore, we cannot guarantee that anyone arriving late will be run past their scheduled appointment time. Each client is important to us and we have to respect the next client's schedule. If for any reason we are running late, you will be guaranteed your scheduled appointment time.

Waiver: I acknowledge that withholding or giving false information can lead to improper treatment which the therapist cannot be held liable for. I swear the information given on this form is complete, accurate and truthful.

Signature: _____