MASSAGE THERAPY HEALTH HISTORY FORM

The information requested below will assist us in treating you safely and effectively. Please note that all information provided below will be kept confidentially unless allowed or requested by law (your written permission will be required). If at any time you have any questions regarding your visit, please feel free to ask!

Name: Today's Date:

E-mail: Phone: (H) (C) (W)

Address: City: Postal Code:

Occupation: Date of Birth:

Your Primary Care Physician - Name & Address:

Where did you hear about Leslie Curnew, RMT?

Have you had a massage before? YES NO Frequency

What brings you in for a massage?

Overall, how is your general health?

Prefered method of contact: Phone Text E-Mail

Please indicate conditions you are experiencing or have experienced:

CARDIOVASCULAR

CURRENT PREVIOUS

- High Blood Pressure
- Low Blood Pressure
- Chronic Congestive Heart failure
- Heart Attack
- Phlebitis/Varicose Veins
- Stroke/CVA
- Pacemaker or similar
- Poor circulation
- Heart disease

RESPIRATORY

CURRENT PREVIOUS

- Chronic Cough
- Shortness of breath
- Bronchitis
- Asthma
- Emphysema
- Breathing problems
- Smoker

HEAD / NECK

CURRENT PREVIOUS

- Headaches
  Type:
- Vision problems
- Earaches
- Vertigo / Dizziness
- TMJ Dysfunction

Therapist Use Only:

Blood Pressure

____ / ____

WOMEN

CURRENT PREVIOUS

- Menstrual Problems
- Gynecological Conditions:
  What?

Pregnant? YES NO

Due Date:

Number of Children:

INFECTIONS

CURRENT PREVIOUS

- Hepatitis
- Herpes
- Skin Conditions
- TB
- HIV / AIDS

OTHER HEALTH CARE

CURRENT PREVIOUS

- Massage Therapy
- Chiropractic
- Physiotherapy
- Psychotherapy
- Regular Exercise

CURRENT MEDICATIONS

Medication:

Condition:

Medication:

Condition:

Medication:

Condition:

OTHER CONDITIONS

CURRENT PREVIOUS

- Liver
- Gall Bladder
- Kidney Bladder
- Diabetes
  Onset:
- Insomnia
- Cancer
  Where?
- Epilepsy
- Constipation
- Digestive Difficulties
- Allergies / Hypersensitivity
  What?
- Loss of Sensation
  Where?

Arthritis, or family history of? YES NO

Affected Areas

Any internal wires, pins, artificial joints? YES NO

Where?

PREVIOUS INJURIES/SURGERIES

Nature:

Date:

Nature:

Date:

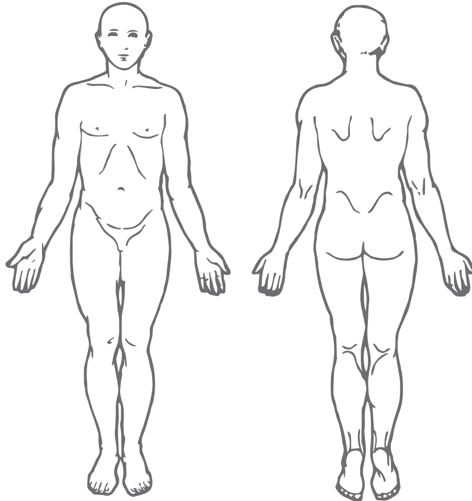
Nature:

Date:

LESLIECURNEW
REGISTERED MASSAGE THERAPIST

MASSAGE THERAPY HEALTH HISTORY FORM

Please mark an "X" on the picture where you feel discomfort.



Please check off where you feel discomfort.

Neck	Upper Back	Lower Back	Mid Back
Arms	Hands	Hips	Thighs
Lower Legs	Knees	Ankles	Feet
Chest	Abdomen	Head	Gluteals / Buttocks
Other:			

My main concern is:

It feels: mild moderate severe

Please circle your pain level. (10 being the most intense) 1 2 3 4 5 6 7 8 9 10

Pain Description:

Sharp	Shooting
Dull	Tightness
Throbbing	Tingling
Burning	Numbness
	Other:

I feel it worse in the: morning afternoon evening after activities

Things that relieve my concern:

Rest	Ice
Medication	Activity
Heat	Other:

Things that aggravate my concern:

Standing	Coughing
Sitting	Bending
Moving	Lifting
Other:	

INFORMED CONSENT

I understand that the purpose of massage therapy is to restore and maintain the integrity of the musculo-skeletel system. I understand that massage therapy is a hands-on healthcare discipline that will require the therapist to place his/her hands on those parts of the body that are involved in the cause of my symptoms. I am aware that my therapist is a Registered Health Care Professional and has the right to discontinue the treatment at their discretion.

I understand that I have complete control of my own treatment and the right to change/alter or discontinue the treatment at any time should I feel uncomfortable.

I understand that massage therapists do not diagnose illnesses, disease or any physical or mental disorders; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations.

I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I further understand that in the practice of massage therapy there is the potential for mild side effects, including, but not limited to muscle soreness/point tenderness in the areas worked (lasting up to 48 hours), mild bruising, headache and possibly feeling lightheaded. Following the treatment, feelings of fatigue are common. Cold packs on achy areas (10 min on, 10 min off) will help minimize any discomfort. Please feel free to call us any time at the clinic if you have any questions or concerns.

Fee is due at the time of treatment; cash and credit cards are accepted.
Without 24 hours notice, you will be billed 50% of the fee for your missed appointment.

I (please print name) have read and acknowledge all the above information and give my consent for massage Treatment and Assessment.

Signature: Date:

UPDATED

Date:	Client Signature	Blood Pressure:
Date:	Client Signature	Blood Pressure:
Date:	Client Signature	Blood Pressure:
Date:	Client Signature	Blood Pressure: