bayview sheppard **RMT**

REGISTERED MASSAGE THERAPY

HEALTH HISTORY

Please print clearly. This information is confidential and will be used to assist the massage therapist in determining a treatment approach suitable to your health care needs.

Today's Date: _____

Last Name _____ First Name _____ M/F _____ D.O.B (M/D/Y) _____

Address _____ Suite.# _____ City _____ Postal Code _____ Telephone (Home) _____

Occupation _____ email address: _____ Telephone (Cell) _____

Physician's Name _____ Address of Physician _____ Telephone _____

Emergency Contact _____ Telephone _____

How did you hear about our clinic?

Friend/Family_____ Internet___ Mail___ Sign___ Other (Please specify)_____
(name)

PRESENT COMPLAINT:_____

Other type of treatment or therapies for this present condition

Chiropractic ____ Physiotherapy ____ Medical Doctor ____ Acupuncture ____ Massage Therapy ____

Have you taken any medication for this condition? yes ☐ no ☐

If yes, please indicate the name of the medication and the dosage amount. _____

When was the last dosage taken _____

What are your expectations of massage treatment _____

Do you have any allergies to nuts, oils, creams? _____

Are you presently taking any other medications?

Name of medication (s) _____ For what condition (s) _____

Are you presently undergoing any type of treatment/therapy?

Name of therapy _____ For what condition (s) _____

Injuries

Types _____

Date _____

Current Symptoms _____

Overall Health: _____

Surgeries

Types _____

Date _____

Current Symptoms _____

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

please complete the reverse side of this form

Please indicate if you have any of the following conditions

P - previous C - current

Cardiovascular

Family History of Cardiovascular conditions	Y	N
	☐	☐

	P	C
high blood pressure	☐	☐
low blood pressure	☐	☐
poor circulation	☐	☐
heart disease	☐	☐
swelling in ankles	☐	☐
chronic congestive heart failure	☐	☐
stroke	☐	☐
myocardial infarction (heart attack)	☐	☐
pacemaker	☐	☐
pain over heart	☐	☐
blood clots	☐	☐
varicose veins	☐	☐
phlebitis	☐	☐

Digestive

	P	C
constipation	☐	☐
difficult digestion	☐	☐
liver/gall bladder	☐	☐
Crohn's disease	☐	☐
colitis	☐	☐
ulcers	☐	☐
diabetes	☐	☐

type:_____
injection site:
current _____
previous _____

Other Conditions

	P	C
hemophilia	☐	☐
epilepsy	☐	☐
fibromyalgia	☐	☐
chronic fatigue syndrome	☐	☐
polio/post polio syndrome	☐	☐
cancer where? _____	☐	☐
anaphylaxis	☐	☐
other diagnosed medical diseases/conditions	☐	☐

Respiratory

Family History of Respiratory conditions	Y	N
	☐	☐

	P	C
asthma	☐	☐
bronchitis	☐	☐
emphysema	☐	☐
short of breath	☐	☐
chronic cough	☐	☐
chest pain	☐	☐

Bone/Joint

Family History of arthritic conditions	Y	N
	☐	☐

	P	C
osteoarthritis	☐	☐
migraines	☐	☐
rheumatoid arthritis	☐	☐
headaches	☐	☐
degenerating disc	☐	☐
vision problems	☐	☐
osteoporosis	☐	☐
scoliosis	☐	☐
herniated disc where? _____	☐	☐
fused disc where? _____	☐	☐
bone spurs where? _____	☐	☐
fracture where? _____	☐	☐

Muscle/Joint

	P	C
neck	☐	☐
upper back	☐	☐
mid back	☐	☐
low back	☐	☐
shoulder	☐	☐
hip	☐	☐
painful tail bone	☐	☐
knee	☐	☐
ankle	☐	☐
foot	☐	☐

Neurological

	P	C
numbness	☐	☐
tingling	☐	☐
shooting pain	☐	☐
carpal tunnel	☐	☐
sciatica	☐	☐
loss of sensation	☐	☐

Female

Other Gynelogical conditions	Y	N
	☐	☐

	P	C
menstrual problems	☐	☐
☐ painful		
☐ heavy		
☐ scant		
breast tenderness	☐	☐
dysmenorrhea	☐	☐
pregnancy	☐	☐
☐ 1st trimester		
☐ 2nd trimester		
☐ 3rd trimester		

	Y	N
menopausal	☐	☐

Surgical Implants

	Y	N
pins where? _____	☐	☐
wires where? _____	☐	☐
artificial joints/limbs where? _____	☐	☐

Skin

	P	C
rash	☐	☐
sensitive skin	☐	☐
plantar warts	☐	☐
eczema	☐	☐
psoriasis	☐	☐
bruise easily	☐	☐
hives	☐	☐
dryness	☐	☐
allergies	☐	☐
other conditions	☐	☐

Head/Neck

	P	C
migraines	☐	☐
headaches	☐	☐
vision problem/loss	☐	☐
ear aches	☐	☐
contact lenses	☐	☐
hearing problem/loss	☐	☐
sinus infection	☐	☐
dizziness	☐	☐

Infectious Cond's

	Y	N
infectious respiratory conditions	☐	☐
tuberculosis	☐	☐
AIDS/HIV	☐	☐
hepatitis	☐	☐

type:_____

Infectious skin

	Y	N
condition (s)	☐	☐

location _____

Please check conditions experienced previously and currently:

Previous:

Where?:

- ☐ muscle strain _____
- ☐ ligament sprain _____
- ☐ tendonitis _____
- ☐ fibrositis _____
- ☐ bursitis _____
- ☐ fracture _____

When?:

- ☐ whiplash _____

Current:

Where?:

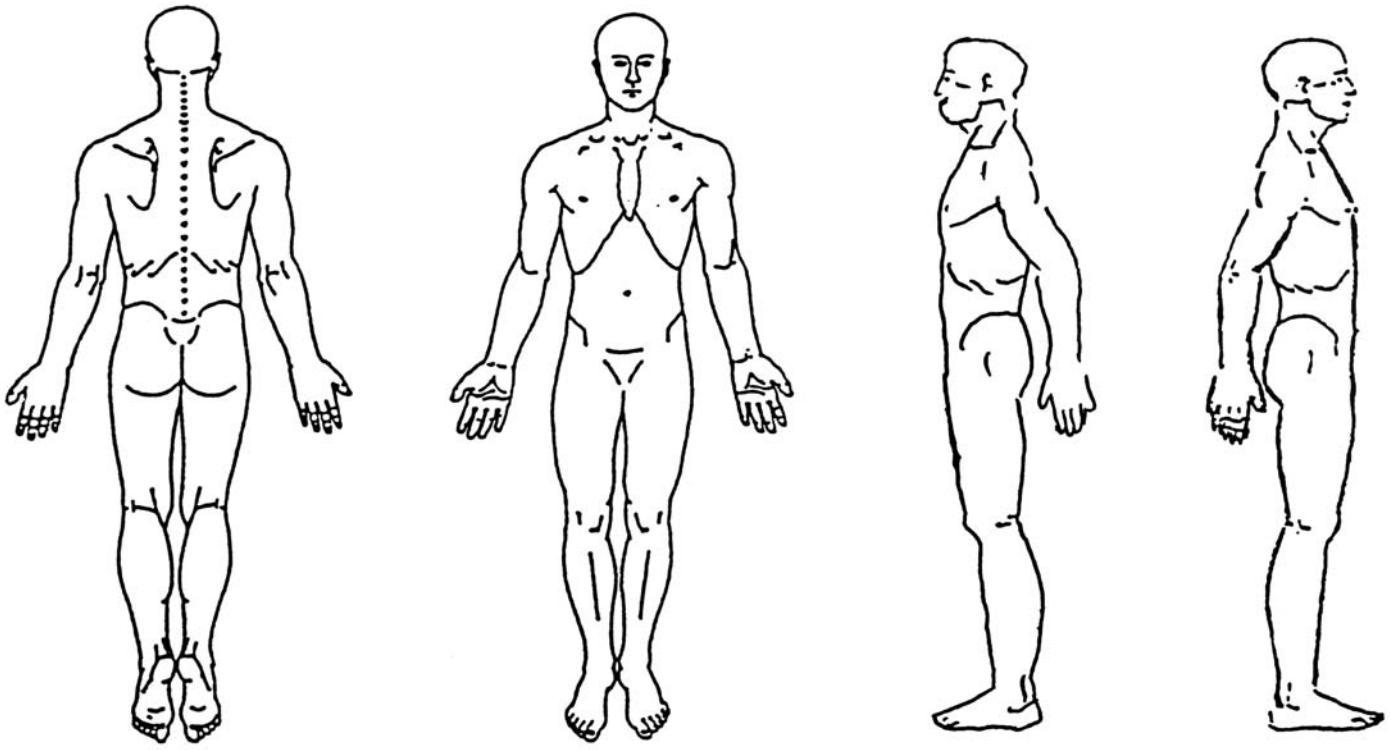
- ☐ muscle strain _____
- ☐ ligament sprain _____
- ☐ tendonitis _____
- ☐ fibrositis _____
- ☐ bursitis _____
- ☐ fracture _____

When?:

- ☐ whiplash _____

Using the appropriate symbols, please indicate any area where you experience pain/discomfort.

Numbness	Pins and Needles	Burning	Aching	Stabbing
+	●	X	0	/



Please indicate if you experience any of the following symptoms during or shortly after physical activity

☐ extreme muscle soreness	☐ difficulty breathing	☐ headaches	☐ chest pains
☐ extreme weakness/fatigue	☐ abdominal discomfort	☐ dizziness	☐ other

Any additional information you would like to provide?_____

_____

_____

I _____verify that the information given on this form is true and accurately reflects my health status. I hereby consent to my course of treatment by the Massage Therapist. I am aware that my file will be kept confidential, however, the file may be shared among any treating practitioners in the clinic, to ensure the utmost quality care. I understand that 24 hours is needed to cancel an appointment or full fee will apply.

Signature _____ Date _____

For therapist use only:

☐ *Consent* ☐ *Fees* ☐ *Terms*

Any Flag? _____

Date: _____ *Initials:*_____

B.P.

INITIAL INTAKE FORM

Client's Name _____Date _____

Therapist's Initials _____ TX Length _____Amt _____Time_____Consent____

Subjective

Present Complaint:

_____

_____

Onset:_____Cause:_____

_____

Previous TX: _____Outcome: _____

Medication for Present Complaint: _____

Medication for Other Condition(s): _____

Allergies: _____

Location of Symptoms: _____

Duration: _____

Radiation: _____

Frequency: _____

Intensity/Painscale: _____

Character: _____

Weakness: _____

Visible Changes: _____

Aggravating Factors: _____

Relieving Factors: _____

Associated Symptoms: _____

ADL-Occupation/Hobbies:_____

Effects on Lifestyle: _____

Sleeping Patterns: _____Hand Dominance:_____

Does present complaint wake up client? _____ Wake with P? _____

Other health concerns to be aware of? _____

Any CIs to treatment?_____

Comments: _____

_____

Objective

Postural Examination: _____

Assessment:_____

_____

_____

_____

_____

_____

_____

_____

Follow up call done:_____

Notes: