The Centre for
Health & Rehabilitation

Massage Therapy
Confidential Case History Form

Name _____ Date of Birth _____

Phone (H) _____ (Cell) _____ (Work) _____

Address _____

_____

Email _____ Occupation _____

Physicians Name & Address _____

_____

What brings you to massage today ? _____

Have you been previously treated for this condition? ☐ Yes ☐ No If Yes By Whom _____

Current medications, vitamins, etc... _____

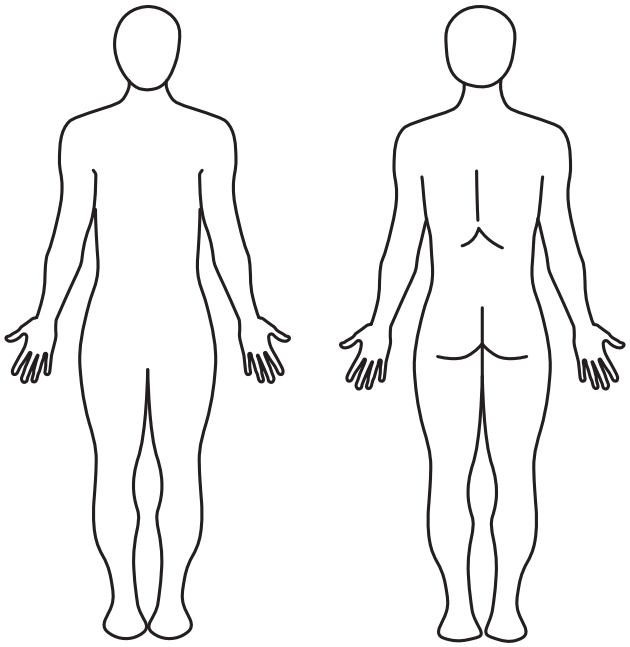
Have you taken any medications in the last 2 hours? ☐ Yes ☐ No if yes, what kind ? _____

Are you experiencing pain right now? ☐ Yes ☐ No _____

Energy Level: ☐ Low ☐ Medium ☐ High Stress Level: ☐ Low ☐ Medium ☐ High

Please indicate area of current symptoms on the figure:

P = pain
X = joint stiffness
S = numbness/tingling
# = area with scars, bruises, open wounds



Previous Injuries/Surgeries/Serious Illnesses/Hospitalizations

1. Type ___ Date ____ Explain _____

_____

2. Type ___ Date ____ Explain _____

_____

1160 Clarence Street Unit 5 & 6
Woodbridge, ON, L4H 2V3
905-652-4811 905-652-4812

Vibrant Square, 2640 Rutherford Road, Ste E201
Vaughan, ON, L4K 0H3
905-553-4814 905-553-4815

www.chrehab.ca

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Please Check Off Conditions You Are Currently Experiencing Or Have Experienced In The Past

Head/Neck

- ☐ Headaches (Stress)
- ☐ Migraines
- ☐ Vision Problems
- ☐ Contact Lenses
- ☐ Earaches

Respiratory

- ☐ Chronic Cough
- ☐ Asthma
- ☐ Shortness Of Breath
- ☐ Bronchitis/Emphysema
- ☐ Smoker
- ☐ Other:

Cardiovascular

- ☐ High Blood Pressure _____
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Heart Disease
- ☐ Myocardial Infarction
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Varicose Veins
- ☐ Hemorrhagic
- ☐ Doctor Diagnosed?

Skin

- ☐ Bruise Easily
- ☐ Skin Conditions
  Type:

Infections

- ☐ Herpes
- ☐ Hepatitis
- ☐ Plantar Warts
- ☐ Tuberculosis
- ☐ H.I.V.

Other Conditions

- ☐ Difficult Digestion
- ☐ Bowei/G.I.
- ☐ Constipation/Diarrhea
- ☐ Liver
- ☐ Gallbladder
- ☐ Kidney
- ☐ Diabetes
- ☐ Sinus
- ☐ Allergies
- ☐ Insomnia
- ☐ Cancer _____
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthirits
- ☐ Thyroid
- ☐ Family History Of Arthritis
- ☐ Epilepsy

Female Issues

- ☐ Menstrual Problems
  Type _____
- ☐ C-Section/Other Surgeries
- ☐ Menopause
- ☐ Infertility
- ☐ Planning Children

Muscles

- ☐ Neck
- ☐ Low Back
- ☐ Middle Back
- ☐ Upper Back/Shoulder
- ☐ Legs Left Right
- ☐ Knees Left Right
- ☐ Feet Left Right
- ☐ Arms/Hands Left Right
- ☐ Other:

Other Health Care

- ☐ Chiropractor
- ☐ Massage Therapy
- ☐ Physiotherapy
- ☐ Accupunture
- ☐ Osteopathy
- ☐ Regular Exercise
- ☐ Other:

Date Of Intial Case History

_____

Update 1 _____

Update 2 _____

Update 3 _____

Update 4 _____

Additional Info/Notes

Any wires, pins, artificial limbs or special equipment? ☐ Yes ☐ No

It is my choice to receive massage therapy and I understand that the treatment being given is for the well-being of my body and mind. I agree to communicate with my therapist any time I feel that my well-being is being compromised. I understand that the therapist will outline the treatment and will commence treatment once consent has been obtained, I understand that I may stop the treatment at anytime I may choose. I acknowledge that massage therapy is not a substitute for medical examination or diagnosis and it is recommended that I see a physician for that service.

I understand that at least 24 hours notice prior to cancelling an appointment is required, or I will be charged for the missed appointment.

Signature: _____ Date: _____

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