Holistic Clinic
Sports and Occupational Injury Management

MASSAGE HEALTH HISTORY FORM

Name_____ Date of Birth_____

Street Address_____ City_____ Postal Code_____

Home/Cell phone _____ Work phone _____ Email_____

Physician Name _____ Address or major intersection of office_____

Occupation_____ Referred by _____

What Brings You In For a Massage _____

Please check the conditions that you are currently experiencing or have experienced in the past:

HEAD/NECK
- ☐ Headaches (tension/ migraine)
- ☐ Vision problems/contact lenses
- ☐ Hearing problems/Earaches
- ☐ Concussion

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Chronic cough/Frequent colds
- ☐ Frequent sinus issues

_____

CARDIOVASCULAR
- ☐ High or Low Blood Pressure
- ☐ Poor circulation/Light headed
- ☐ Heart Disease / Heart Attack
- ☐ Chronic congestive heart failure
- ☐ Pace maker or similar device
- ☐ Stroke
- ☐ Phlebitis and/or Varicose Veins
- ☐ Chest pain /Angina

OTHER CONDITIONS
- ☐ Constipation/Diarrhea
- ☐ Fibromyalgia δChronic Fatigue
- ☐ Liver or Kidney or Gall Bladder
- ☐ Diabetes
- ☐ Epilepsy /Seizures
- ☐ Irritable Bowel Syndrome
- ☐ Insomnia
- ☐ Cancer –Type_____
- ☐ Date of diagnosis_____
- ☐ Allergies-Type_____

_____
- ☐ Parkinson's
- ☐ Multiple Sclerosis

INFECTIONS
- ☐ HIV
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Plantar Warts

SKIN
Bruise easily
Sensation Loss
Skin Conditions – Type_____

JOINT /BONE
- ☐ Arthritis -Type_____
- ☐ Hereditary_____
- ☐ Degenerating Discs
- ☐ Osteoporosis/osteopenia
- ☐ TMJ/ Jaw or ear pain

WOMEN
- ☐ Menstrual Pain
- ☐ Pregnant
- ☐ Due date _____

ACCIDENTS (motor vehicle or falls)
Date: _____

SURGERY
Type & Date: _____
_____
_____

INJURIES (muscle tears, sprains, fractures)
Type & Date: _____
_____
_____

CURRENT MEDICATIONS_____

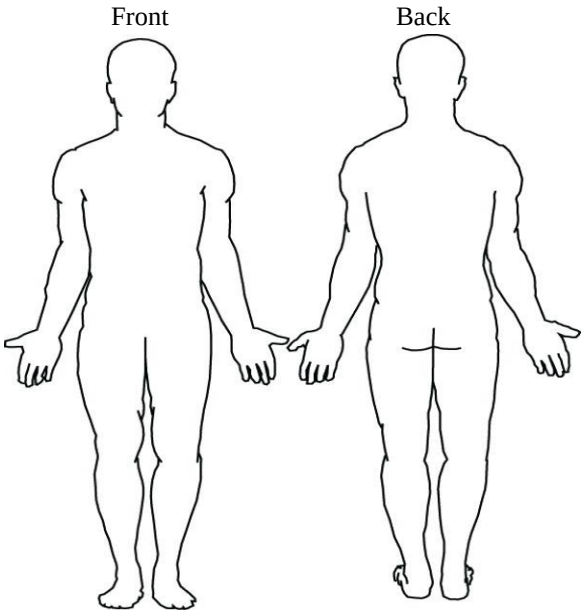
PINS, WIRES, ARTIFICIAL LIMBS, JOINTS_____

OTHER MEDICAL CONDITIONS NOT LISTED _____

OTHER HEALTH CARE: ☐ Physiotherapy ☐Chiropractic ☐Acupuncture/TCM ☐Osteopathy ☐Naturopath ☐ Massage

Please Turn Over and Fill Out Page 2

Indicate areas of muscle or joint discomfort on the image below using the symbols indicated



Stiff/Tight
vv Aching
^^ Burning
xx Pain, Sharp or Stabbing
00 Pins and Needles
/ / Numbness

On a scale of 0 (no pain) to 10 (extreme) how would you rate your pain?
At best_____ At worst _____ usual _____

When did this condition begin? _____
Anything associated with the onset? _____
_____
What increases symptoms_____
_____
What decreases symptoms_____

All information gathered for the massage is confidential and released only with written/verbal consent or when required by law.

SIGNATURE_____ **DATE**_____

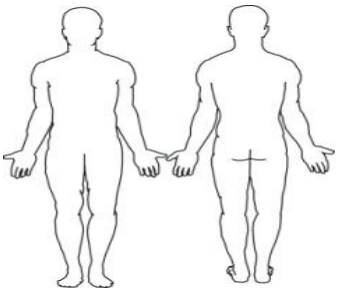
Office use only

Date **Time** **Duration** **Fee** **I/Cδ** **RMT**_____ **Medical Imaging:** _____

PRIMARY GOALS/COMPLAINTS

ASSESSMENT/ NEUROLOGICAL/ASSOCIATED SYMPTOMS

CLINICAL FINDINGS



TREATMENT: ☐ Back ☐ Neck ☐ Ant. Legs ☐ Post. Legs ☐ Arms ☐ Gluts ☐ Psoas
☐ Abdomen ☐ Jaw **HYDRO:** ☐Heat ☐Ice
TECHNIQUES: ☐ Effl ☐ Pettr ☐ trigger pt ☐ friction ☐ myofascial ☐ jt.play ☐ muscle stripping
Other_____
Future recommendation for treatment and Referrals_____

SELF CARE: