444 Dundas Street West
Belleville, ON K8P 1B7
Tel: 613.969.0002
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Confidential Case History

Name: ____________________ Date: ____________________

Address: ____________________ Update: ____________________

Postal Code: ____________________ Phone: ____________________

E-mail: ____________________ Work Phone: ____________________

☐ Consent to e-mail updates and notifications Date of Birth: ____________________

Current involvement in treatment with other practitioners: __________ Occupation: ____________________

Doctor: ____________________ Physiotherapist: ____________________

Address: ____________________ ____________________

Chiropractor: ____________________ Naturopath: ____________________

How did you hear about us? Who may we thank? ____________________

Have you ever had a massage? ____________________ How did you respond to your massage? ____________________

Did you have any reactions to lotions used? ____________________

General Health: ____________________

Primary Complaint: ____________________ For how long? ____________________

What aggravates it? ____________________ What relieves it? ____________________

Type of pain: ☐ Radiating ☐ Sharp/Stabbing ☐ Aching ☐ Constant ☐ Other ____________________

Any loss of sensation? ____________________ Have you had any surgeries? ____________________

Date: ____________________

Do you have any internal pins, wires, artificial joints, etc: __________ Do you have any visual or hearing impairments? __________

Do you have any past or present conditions of cancer? __________ Are you currently taking any medications? __________

Cancer, type: ____________________ If yes, please state what they are and the reason: ____________________

____________________ ____________________

Skin Conditions: ☐ Rashes ☐ Acne ☐ Warts ☐ Eczema ☐ Allergies ☐ Moles ☐ Athlete's Foot
☐ Skin Sensitivities ☐ Other: ____________________

Musculoskeletal: ☐ History of headaches or migraines ☐ Family history of Arthritis: ☐ Rheumatoid ☐ Osteoarthritis
☐ Tendonitis Where? ____________________

☐ Strains/Sprains Where? ____________________

☐ Spasms/Cramps Where? ____________________

☐ Joint Stiffness/Swelling Where? ____________________

☐ Bursitis Where? ____________________

☐ Jaw Pain/TMJ Where? ____________________

☐ Bone of Joint Disease Where? ____________________

☐ Carpal Tunnel ☐ Herniations ☐ Thoratic Outlet Syndrome ☐ Prolapsed Disc

☐ Other: ____________________

Cardiovascular/Circulatory:

☐ Dizziness/Fainting ☐ Heart Disease ☐ History of Myocardial Infarction

☐ High Blood Pressure ☐ Low Blood Pressure ☐ History of Cerebrovascular Accident

☐ Angina ☐ Stroke ☐ Phlebitis/Varicose Veins

☐ Pacemaker or other device ☐ Hemophilia ☐ Aneurysms

☐ Family history of cardiovascular difficulties: ____________________

Respiratory:

☐ Chronic Cough ☐ Asthma ☐ Bronchitis ☐ Emphysema

☐ Shortness of Breath ☐ Sinus Problems

☐ Family history of respiratory difficulties: ____________________

Nervous System:

☐ Numbness/Tingling ☐ Parkinson's Disease ☐ Sleeping Disorders ☐ Multiple Sclerosis

☐ Fatigue ☐ Fibromyalgia ☐ Herpes/Shingles ☐ Epilepsy

☐ Chronic Fatigue System ☐ Other: ____________________

Reproductive and Digestive System:

Are you pregnant? ____________________ When are you due? ____________________

☐ Diabetes ☐ Constipation ☐ Irritable Bowel Syndrome ☐ Diarrhea

☐ Crohn's Disease ☐ Ulcers

Please list any other diagnosed gynecological or digestive conditions: ____________________

Infectious Conditions:

☐ Infectious Skin Conditions ☐ HIV ☐ Tuberculosis ☐ Herpes

☐ Hepatitis ☐ Infectious Respiratory Conditions: ____________________

Massage therapy is a holistic approach to maintaining a healthy lifestyle. Your treatment may include any of the following body parts: back, arms, hands, gluteals, legs, feet, neck, face, scalp. If there are any areas of the body you do not wish to have massaged, please specify: ____________________

The therapist only undrapes the body part being treated and then promptly redrapes the area following treatment. It is within your right to stop or alter the treatment plan at any time throughout the duration of your treatment. The therapist will go over your treatment plan with you prior to treatment.