CONFIDENTIAL CASE HISTORY
MASSAGE THERAPY

Date: ______________________________

Email address: ______________________

Last Name			First Name		
Date Of Birth	Male “ Female “		Marital Status M W S D	# Children	
Address	City			Postal Code	
Home Phone Number	Work Phone Number			Occupation	
How did you hear about us?	Do you have EXTENDED HEALTH CARE INSURANCE for massage therapy? Yes No	Is this your first massage? Yes No	Previous massage care? R.M.T.’s Name?	Is this: MVA “ WCB “	
Medical Doctor’s Name			Doctor’s Phone Number		

Reason for consulting massage therapist:

“ I have no symptoms and I feel well. I am interested in strategies to help me continue to feel well, or even better.
“ After my specific problem has been relieved and I understand methods of ensuring it does not return, I am interested in strategies to improve my general health, including regular massage therapy treatments.
“ I have a specific problem and require help with this problem only.

CURRENT HEALTH CONDITION

What brings you in to see us?	
When did it start?	Have you had a similar problem in the past?
The condition is: “ constant “ comes & goes “ getting worse	The condition is interfering with: “ work “ sleep “ daily routine “ sports
Have you consulted others regarding this condition? “ chiropractor “ massage therapist “ physiotherapist	How long has it been since you’ve felt good?
What makes your condition: Worse? ____________________ Better? ____________________	
Please list any major illnesses and surgeries:	
Have you ever been in a car accident, if yes when?	
Do you have any other health complaints?	

RELEVANT HEALTH HISTORY

Do you smoke? Yes “ No “	I sleep on my: “ back “ side “ stomach	Do you sleep well? Yes “ No “
What exercises do you do?	What current medication or natural supplements do you take?	Conditions these medications treat?

Would you like a silent massage?	Are you allergic to any oils/lotions/aromatherapy?	What kind of pressure do you like? “ very deep “ deep “ medium “ light “ not sure	Are you pregnant? Due Date: ___________

Please check the conditions you are experiencing now or have in the past:

GENERAL	RESPIRATORY	CARDIOVASCULAR	SKIN
“ allergies “ convulsions “ dizziness “ fatigue “ headaches “ fibromyalgia “ chronic fatigue syndrome	“ chronic cough “ shortness of breath “ bronchitis “ asthma “ emphysema	“ high/low blood pressure “ chronic congestive heart failure “ heart/disease attack “ phlebitis “ stroke/CVA “ pacemaker	“ rash “ sensitive “ eczema “ bruise easily “ varicose veins “ psoriasis
HEAD/NECK	**WOMEN**	**MEN**	**COMMUNICABLE DISEASES**
“ ear problems “ vertigo “ blurred vision “ earaches “ vision loss “ sinus	“ menstrual problems “ menopausal problems	“ prostate cancer “ testicular cancer	“ TB “ hepatitis “ HIV

OTHER CONDITIONS

“ cancer	“ epilepsy	“ internal pins/wires
“ arthritis OA	“ hemophilia	“ artificial joints
“ arthritis RA	“ diabetes - Onset: _______________	“ degenerated discs

MUSCLE PAIN AND TENSION

NECK	SHOULDERS	ARM	LEG	BACK
“ right “ left	“ right “ left	“ right “ left	“ right “ left	“ upper “ mid
“ front “ back	“ front “ back	“ front “ back	“ front “ back	“ lower

Do you experience any of the following?

“ dizziness/fainting “ pain that wakes you up at night “ allergic reactions “ tiredness/fatigue

Has it been more than 6 months since your last massage?	What are your favourite parts of a massage? (Ie: feet, shoulders)

I understand and agree that the following information on this form is accurate, current and will be confidential. Please feel free to adjust the depth/techniques of the massage treatment at any time by telling the therapist.
YOU ARE ALWAYS IN COMPLETE CONTROL OF THE TREATMENT.

______________________________ ______________________________

signature date

MASSAGE THERAPY
OFFICE PROCEDURE CONSENT

PLEASE READ CAREFULLY AND THOROUGHLY

I hereby request and consent to massage therapy soft-tissue manipulation and other related procedures.

I have discussed with a therapist and/or with other office or clinic personnel the nature and purpose of therapeutic massage and other related procedures. I understand that results will vary depending on the individual and the extent of their condition.

I understand and am informed that, as in all health care, there are some risks to treatment which, if applicable, will be discussed before the treatment. I wish to rely on the therapist to exercise judgement during the course of the procedure based upon facts then known.

At Filosofi, we value you as a friend and patient. We strive to provide a relaxing, educating, and healthy atmosphere. Our therapists treat everyone with respect and trust, and so deserve the same in return. They work a limited number of hours each week to ensure the best possible care. Under these conditions, the clinic must reserve the right to charge the full fee for a missed appointment with less than twenty-four (24) hours notice. Also, the right is reserved by the clinic to charge the full scheduled fee for tardiness of appointments, and/or request that appointments are secured by Visa or MasterCard.

I have read the above and have had an opportunity to ask questions about it's content.

Fees: 60 minute massage .... $70.00.00 (tax incl.)
30 minute massage .... $45.00 (tax incl.)

Patient: ____

Signature: __________________________________ **Date:** _______________

FOR OFFICE USE ONLY

VISA/MC # __________________________________ Exp. _______________