Health MOMENTUM CENTRE FOR THERAPEUTIC MEDICINE

HEALTH HISTORY FORM FOR REGISTERED MASSAGE THERAPY
JESSICA STALLER, R.M.T.

Name: _____ Date of Birth: _____
Address: _____
City: _____ Postal Code: _____
Phone: Home: _____ Work: _____ Cell: _____
Occupation: _____
E-mail Address: _____
Family Doctor: _____ Phone Number: _____
Emergency Contact: _____ Phone Number: _____
How did you hear about us? Friend Family Internet Phone Book Brochure
If you were referred by someone please specify: _____
Do you have extended healthcare? Yes / No If yes, with who? _____

Have you had massage therapy before? YES NO

Reason for today's massage appointment? _____

PLEASE LIST ALL SURGERIES
1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

CURRENT MEDICATIONS
1. _____ Purpose: _____
2. _____ Purpose: _____
3. _____ Purpose: _____
4. _____ Purpose: _____

Please indicate conditions you are experiencing or have experienced

CARDIOVASCULAR
□ High Blood Pressure
□ Low Blood Pressure
□ Heart Disease
□ Heart Attack
□ Stroke
□ Varicose Veins
□ Bruise Easily

RESPIRATORY
□ Chronic Cough
□ Breathing Difficulty
□ Bronchitis
□ Asthma
□ Emphysema

Do you smoke? Yes No

INFECTIONS
□ Hepatitis A B C
□ Tuberculosis
□ HIV/AIDS
□ Herpes

SKIN
□ Eczema
□ Psoriasis
□ Acne
□ Plantar Warts

DIGESTIVE / URINARY
□ Constipation
□ Diarrhea
□ Chrons / Colitis
□ Ulcers
□ Gallbladder
□ Liver
□ Kidney Infection
□ Bladder Infection

HEAD & NECK
□ Headache
□ Herniated Disc
□ Scoliosis
□ Dislocation
□ Fracture

OTHER CONDITIONS
□ Diabetes
□ Allergies
□ Cancer
□ Fibromyalgia
□ Multiple Sclerosis
□ Migraine
□ Whiplash
□ Jaw Pain
□ Ear Pain
□ Hearing Loss
□ Vision Loss / Other Concerns

WOMEN
□ Menstrual Concerns / Pain
□ Endometriosis
□ Menopausal Concerns
□ Hysterectomy
□ Pregnant
Due Date? _____

MUSCLE / JOINT
□ Muscle Strain
□ Ligament Sprain
□ Tendonitis
□ Bursitis
□ Arthritis OA RA
□ Osteoporosis
□ Epilepsy
□ Motor Vehicle Accident

OTHER HEALTH CARE
□ Chiropractic
□ Acupuncture
□ Medical Doctor
□ Physiotherapy
□ Naturopathy
□ Osteopathy
□ Other: _____

An accurate health history is important to ensure that it is safe to receive a massage therapy treatment. All information given before, during and after treatments will be held in strict confidence. You will be asked to provide written authorization for release of any information.

You will be required to review, revise and update your health history on a yearly basis as per regulations of the College of Massage Therapists of Ontario.

Signature _____ Date _____

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