

# North Brentwood Massage Therapy Clinic

## CLIENT CASE HISTORY

This information is considered confidential and will only be used to provide you with safe, effective treatment. This information may not be released without your written consent unless required by law.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_ month \_\_\_\_\_ day \_\_\_\_\_ year

Postal Code: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ \*E-MAIL: \_\_\_\_\_

Work Telephone: \_\_\_\_\_ (for appointment reminders)

Cell phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_

Did someone refer you for massage therapy? Yes \_\_\_ No \_\_\_ If yes, who: \_\_\_\_\_

What is your main reason for coming? \_\_\_\_\_

Other Complaints: \_\_\_\_\_

Aggravating Factors: \_\_\_\_\_

Do You Exercise/play sports? \_\_\_\_\_

Have you had previous Massage Therapy treatments? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you currently involved in any other form of rehabilitation/therapy or healthcare? \_\_\_\_\_

Please check the conditions that apply to you

### Respiratory

- Chronic cough
- Shortness of breath
- Bronchitis
- Emphysema
- Asthma
- Smoker

### Infections

- Menstrual difficulties
- Hepatitis
- Tuberculosis
- HIV+
- Herpes
- Skin Conditions/disease
- Other \_\_\_\_\_
- \_\_\_\_\_

### Men

- Prostate problems

### Women

- Menstrual difficulties  
\_\_\_\_\_
- Gynecological conditions;  
What? \_\_\_\_\_
- Pregnant: \_\_\_\_\_ mos.  
Due date: \_\_\_\_\_
- Menopause  
Since \_\_\_\_\_

### Cardiovascular

- High/Low blood pressure;  
B/P \_\_\_\_\_
- Poor circulation
- Heart disease
- Angina
- Atherosclerosis  
(hardening of the arteries)
- Fainting
- Stroke/CVA
- Phlebitis/varicose veins
- Hemophilia
- Heart attack  
(Date: \_\_\_\_\_)
- Pacemaker
- Chronic Congestive Heart  
Failure

### Skin

- Sensitive skin
- Rashes
- Cold sores
- Bruise easily
- Psoriasis/eczema:  
Location \_\_\_\_\_

### Other Conditions

- Seizures/Epilepsy
- Diabetes: type \_\_\_\_\_
- Constipation
- Hernia
- Cancer: type \_\_\_\_\_
- Loss of sensation
- Headaches/migraines
- Ear problems
- Vision loss
- Hearing loss
- Vision problems
- Contact lenses
- Dizziness
- Allergies: type \_\_\_\_\_
- Arthritis type \_\_\_\_\_
- Family history of arthritis

### Please check areas of concern

- Neck
- Shoulder R or L
- Back (upper/mid/low)
- Gluteus/Buttock
- Leg R or L
- Arm/hand R or L
- Elbow R or L
- Wrist R or L
- Knee R or L
- Ankle R or L
- Feet R or L

- Stiffness/limited movement: where? \_\_\_\_\_
- Numbness/Tingling/Electric-pain: where? \_\_\_\_\_

Please list any other health conditions, ie. Multiple Sclerosis, Fibromyalgia, Degenerative Disc Disease, etc.

	Date diagnosed
	Date diagnosed
	Date diagnosed

Have you ever been in an **automobile accident**? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of accident: \_\_\_\_\_ Injury Sustained: \_\_\_\_\_

Treatment received, ie/ physiotherapy \_\_\_\_\_

Do you have any: **pins, plates, prosthesis, pacemaker or wires**? \_\_\_\_\_

Please list all medications

	Condition it treats
	Condition it treats
	Condition it treats

Please list surgeries or injuries

	Date: _____
	Date: _____
	Date: _____

Any there any other comments or concerns about your health?

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**Massage Therapy is the manipulation of soft tissues of the body to gain a therapeutic response. Soft tissues include: muscles, tendons, ligaments and skin.**

Please be advised that 24 hours notice is required in the event of a cancellation to avoid a cancellation fee.

\_\_\_\_\_  
signature

\_\_\_\_\_  
date

health history update

Update #1 \_\_\_\_\_  
signature

\_\_\_\_\_  
date

\_\_\_\_\_  
signature

\_\_\_\_\_  
date

\_\_\_\_\_  
signature

\_\_\_\_\_  
date

\_\_\_\_\_  
signature

\_\_\_\_\_  
date