PhysioCare Wellness & Rehab

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Mon–Fri 9:00am–6:30pm · Sat 9:00am–4:00pm · Sun closed

Massage Therapy — Health History Form

Please complete this form before your first massage therapy visit. Information is collected under PHIPA and kept confidential in your clinical chart.

Patient information

First name _____

Last name _____

Date of birth (YYYY-MM-DD) _____

Phone _____

Email _____

Occupation _____

Address _____

City / postal code _____

Emergency contact name _____

Emergency contact phone _____

Family physician _____

Physician phone _____

Health history

Check any that apply, and add notes below.

[ ] High / low blood pressure
[ ] Heart condition
[ ] Diabetes
[ ] Cancer (current or past)
[ ] Stroke / TIA
[ ] Asthma / breathing issues
[ ] Arthritis
[ ] Osteoporosis
[ ] Disc herniation / sciatica
[ ] Headaches / migraines
[ ] TMJ / jaw pain
[ ] Skin condition / rash
[ ] Pregnancy
[ ] Recent surgery
[ ] Motor vehicle accident
[ ] WSIB / work injury
[ ] Blood clot / DVT
[ ] Contagious illness
[ ] Implants / pacemaker
[ ] Allergies (list below)

Current medications / supplements

_____

Allergies

_____

What brings you in today? (area of pain, onset, what makes it better or worse)

_____

_____

Areas of concern

Mark areas of pain, tension, or restriction:

[ ] Head / face

[ ] Neck

[ ] Shoulders

[ ] Upper back

[ ] Low back

[ ] Hips / pelvis

[ ] Arms / hands

[ ] Legs / feet

[ ] Chest / ribs

[ ] Abdomen

[ ] Other

Have you had massage therapy before? [ ] Yes [ ] No

Pressure preference: [ ] Light [ ] Medium [ ] Firm

Declaration

I confirm that the information on this form is true to the best of my knowledge. I will tell my Registered Massage Therapist about changes in my health. I understand this form becomes part of my confidential clinical record.

Patient / guardian signature	Print name	Date
_____	_____	_____