# Valley Massage Therapy Clinic- Massage Therapy
# Patient Medical History Form

Please complete this form to the best of your ability. Please print

Name: _____ D.O.B.: (dd/mm/yy): ____/____/____
Gender: Male___ Female___
Address: _____ Town: _____ Postal Code: _____ Telephone (h)_____-_____-_____ (c)_____-_____ -_____ (w)_____-_____ - _____
Occupation: _____ email(optional): _____

Private Medical Plan (policy #, ID#):_____

IF MOTOR VEHICLE ACCIDENT: Agent, Phone Number, and Claim Number
_____

Doctor: _____ Town: _____ Telephone: _____-_____ -_____

Chiropractor/Physiotherapist: _____
Company: _____ Telephone: _____-_____-_____

How did get referred to us (friend, signage, physician, website, yellow pages, etc…): _____
Previous Massage: YES NO

**Current Health History:**

| Primary Complaint: |
|---|
| |

Medications (even Tylenol)
→ Reason:
→ Reason:
→ Reason:

Relieving Factors: Heat Ice Exercise
Sleeping Patterns: _____
Do you have Pain at night? YES OR NO If yes, please describe:
_____

Exercise Regularly? YES or NO If yes, please describe type and frequency:
_____

Do you drink alcohol or smoke? : YES or NO

Other Modalities tried (Physio/Chiropractor/Osteopath/etc…): _ _____

Surgeries (with dates and treatments):

_____

_____

Plates/Pins/Screws/Pace Maker: YES or NO

Previous injuries and treatments (i.3. MVA, Strains, Sprains, Fractures, etc…):

_____

_____

## Medical History:

**Cardiovascular:**
- ( ) Hemophilia
- ( ) Hypertension
- ( ) Myocardial Infraction
- ( ) CVA (Strokes)
- ( ) Dizziness
- ( ) Poor Circulation
- ( ) Phlebitis
- ( ) Varicose Veins
- ( ) Chest Pains

**Digestive**
- ( ) Indigestion
- ( ) Constipation
- ( ) Diarrhea
- ( ) Diverticulitis
- ( ) IBS
- ( ) Chron's Disease
- ( ) Colitis
- ( ) Liver/Gallbladder problems
- ( ) Kidney Disease

**Neurological:**
- epilepsy
- ( ) Multiple Sclerosis
- ( ) Cerebral Palsy
- ( ) Muscular Dystrophy
- ( ) Parkinson's
- ( ) Spinal Cord Injury
- ( ) Paralysis
- ( ) Numbness/Tingling
- ( ) Neuritis/Neuralgia

**Skin:**
- ( ) Acne
- ( ) Athlete's Foot
- ( ) Bruise Easily
- ( ) Sensitive Skin
- ( ) Rashes/Eruptions

**Respiratory:**
- ( ) Asthma
- ( ) Emphysema
- ( ) Bronchitis
- ( ) Shortness of Breath
- ( ) Sinus Problems
- ( ) Chronic Cough
- ( ) Allergies: _____
  _____

**Reproductive:**
- ( ) Pregnancy
- ( ) PMS
- ( ) Menopause
- ( ) Pelvic Inflammatory Disease
- ( ) Prostate Problems
- ( ) Endometriosis
- ( ) Hysterectomy

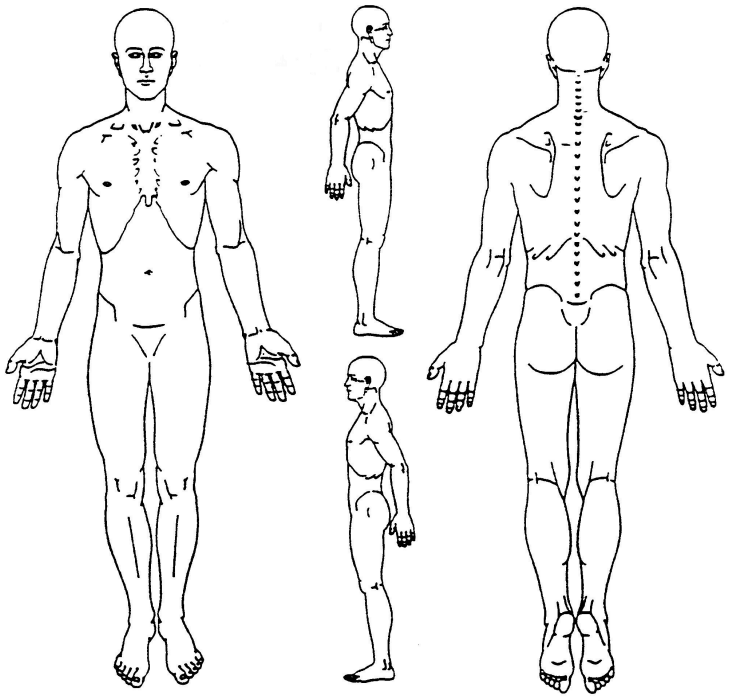
**Muscle/Joints:**
- ( ) Joint Stiffness
- ( ) Arthritis/OA/RA
- ( ) Osteoporosis
- ( ) Limited Movement
- ( ) Excessive Movement
- ( ) Dislocations
- ( ) Broken Bones
- ( ) Jaw Pain/ TMJ
- ( ) Scoliosis
- ( ) Bone or Joint Disease
- ( ) Swelling
- ( ) Sprains/Strains
- ( ) Tendinitis
- ( ) Bursitis
- ( ) Spasms/ Cramps
- ( ) Neck/ Head Pain
- ( ) Back/ Hip Pain
- ( ) Leg/ Knee/ Foot pain
- ( ) Shoulder/ Arm Pain
- ( ) Wrist/ Hand Pain
- ( ) Chest/ Abdominal Pain

**Other:**
- ( ) Herpes/ Shingles
- ( ) Hepatitis
- ( ) HIV/ AIDS
- ( ) TB
- ( ) Cancer(where)_____
- ( ) Diabetes
- ( ) Hearing/ Vision loss
- ( ) Insomnia
- ( ) Fainting
- ( ) Loss of Appetite
- ( ) Depression
- ( ) Stress
- ( ) Fibromyalgia
- ( ) Chronic Fatigue Syndrome
- ( ) Post/ Polio Syndrome
- ( ) Migraines

Please record any other information that may be helpful:

_____

_____



**Please indicate your areas of pain or discomfort.**

**If necessary, notes may be made beside the figure.**

**WHAT TO EXPECT AT YOUR FIRST APPOINTMENT:**

After filling out the Medical History Form, you will be escorted into the clinic room. The therapist will then do a mandatory 20-30 minute assessment with you. This assessment enables the therapist to localize where the problems exist, identify any contributing factors that may have led to the condition, how your activities of daily living have been affected, and also to formulate an effective treatment plan. Massage Therapists are not allowed to diagnose a client, but we are allowed to make clinical impressions. After the assessment the therapist will instruct you how to get on the table. During the massage, your body is always draped, except for the area that the therapist will be working on. He/she will inform you of the specific draping for that body region prior to undraping it. After the massage, the therapist will instruct you on how to get off the table. After you get dressed, the therapist may proceed with a short reassessment and home care. He/she will leave the room when you are undressing or getting dressed, unless assistance is needed. On following visits, a short consultation will be done to see if there are any changes since the last visit.

## Cancellation Policy:

***Please provide 24 hours notice for any changes to your appointment time. For missed appointments or late cancellations a $40 fee may be charged to you personally (insurance companies will not pay for missed appointments).***

I give *Valley Massage Therapy Clinic* and its therapists permission to contact me by TEXT, PHONE, and EMAIL to arrange appointments and for periodic marketing.
Initial: _____

I understand that all the information contained in this form is confidential, and will only be discussed with a third party when necessary to help aid in the management of my case. I will authorize the release of my information either verbally or in writing when a lawyer, Insurance company or another professional requests for it in writing. Consent for release of this information to my family physician or referring practitioner is assumed by signing this form.

I understand that I have the right to withdraw my consent for treatment or the release of information at any time with written notification to Valley Massage Therapy Clinic.

Signature: _____ Date: _____