CONFIDENTIAL Medical Case History Form

Name (printed): ______________________________ Signature_____________________________ Date ________________

Address____

Home#__________________ Office___________________ Mobile______________ Email_________________________

I consent to receive reminders, updates, communication from "helping hands massage therapy" (Initials) ____________

Occupation_______________________________ D.O.B.__________________ Height _________ Weight_____________

Dr's Name______________________________ Address_________________________________ Office #_______________

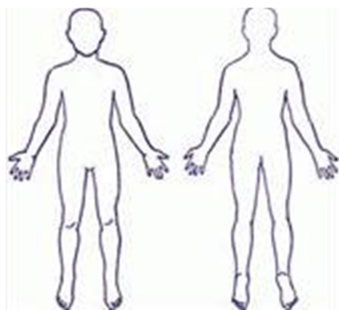
Current medications (Including non-prescription) ____

____

Have you recently been in a motor vehicle accident/work related injury to which you will be making a claim Y ____ N___

Allergies? ____

How did you hear about "helping hands massage therapy" ____Referral____



What is your primary complaint ____?

Can you describe it? (Circle) DULL SHARP SHOOTING ACHY NUMB TINGLING STUFF

Pain scale: (low) 1-------5-------10 (high) does it radiate anywhere? ____________________

Does anything aggravate it?____

Does anything relieve it?____

Where did your symptoms begin__________________________ have they changed & how ________________________

____

Is this condition interfering with: WORK SLEEP DAILY ROUTINE ACTIVITIES (please explain) ______________________

____

Have you seen any other health care practitioner concerning this complaint: MD __ Chiropractor __ Physiotherapist __ Massage Therapist __ Other __ Have they provided results? ____

Surgery /Injuries / hospitalization: (dates, past and current symptoms) _______________________________________

____

Do you have any internal pins/wires/artificial joints?____

212 Marsellus Dr. Barrie Ontario L4N 9Z5 705-797-0068 helpinghandsbynancy@gmail.com
www.helpinghandsbynancy.com

Please check all that apply:

HEAD/NECK

- ☐ Headache
- ☐ Migraine
- ☐ Visual Disturbances
- ☐ Contact Lenses/Glasses
- ☐ Earaches
- ☐ Hearing Problems
- ☐ Jaw Pain / Dental Problems
- ☐ Whiplash

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chronic Congestive Heart Failure
- ☐ Poor Circulation
- ☐ Heart Disease
- ☐ Phlebitis
- ☐ Varicose Veins
- ☐ Stroke
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Arteriosclerosis
- ☐ Irregular Heart Beat
- ☐ Family history of heart disease: ______________________

RESPIRATORY

- ☐ Asthma
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Smoker
- ☐ Family history of lung problems: ______________________

DIGESTIVE/URINARY

- ☐ Difficult Digestions
- ☐ Constipation
- ☐ Liver/Gallbladder
- ☐ Kidney/Urinary
- ☐ Diabetes (type & onset): ______________________
- ☐ Hypoglycemia
- ☐ Crohn's Disease
- ☐ Irritable Bowel
- ☐ Ulcers
- ☐ Family history of diabetes: ______________________

SKIN

- ☐ Bruise Easily
- ☐ Eczema
- ☐ Psoriasis
- ☐ Sensitivity
- ☐ Skin Condition (please specify): ______________________
- ☐ Loss of Sensation (describe): ______________________
- ☐ Athlete's Foot
- ☐ Cold Sores
- ☐ Plantar Warts

INFECTIOUS CONDITIONS

- ☐ Tuberculosis Y N
- ☐ AIDS/HIV Y N
- ☐ Hepatitis Y N
  Type: ______________________
- ☐ Infectious Skin Conditions Y N
  ____

MUSCLE/JOINTS

- ☐ Neck
- ☐ Low Back
- ☐ Mid Back
- ☐ Upper Back
- ☐ Shoulder
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Other: ______________________

FEMALE

- ☐ Menstrual Problems
- ☐ Pregnancy
  Due Date: ______________________
- ☐ Menopausal Problems
- ☐ Gynaecological conditions

OTHER

- ☐ Hemophiliac
- ☐ Epilepsy
- ☐ Cancer
  Location: ______________________
- ☐ Family history of cancer? ______________________
- ☐ Arthritis OA RA
  Family history of arthritis: ______________________
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Family history of osteoporosis: ______________________
- ☐ Chronic Fatigue Syndrome
- ☐ Scoliosis
- ☐ Carpal Tunnel Syndrome
- ☐ Fainting/Dizziness/Loss of Consciousness
- ☐ Hernia

How is your general health? ____

May I please contact you by telephone, Canada Post, Email or eNewsletter regarding updates, appointment re-booking or any changes/updates to my office? **YES** ☐ **NO** ☐

This is to confirm and acknowledge that the above-mentioned information is correct and accurate to my knowledge and that I give consent for my treatment by a Registered Massage Therapist. I also acknowledge the policy that appointments cancelled with less than 24 hours notice or missed appointments will be subject to full fee charge.

Signature: ______________________________ Date: ____________________