Massage Therapy Practice of: Jo-Anne Racette, MEd, RMT

Medical Professional Centre, 658 Danforth Avenue, Suite 409, Toronto, ON M4J 5B9
Telephone: 416-465-8179

CASE HISTORY OUTLINE

The information on this form is confidential and will be used for no other purpose than for the development and practice of safe and effective treatment plans.

Name: _____ Telephone: _____ Work

Address: _____ _____ Home
Street #, Ste#, City, Prov, Postal Code

Date of Birth: _____ Weight: _____ Height: _____ Occupation: _____

Where did you first hear about the clinic? _____ Email: _____
Pls be specific: eg: Name of friend/Doctor/Internet, etc.

What brings you in for a massage? _____

Health History: Please check the conditions that you are currently experiencing or have experienced often in the past

Current	Previous	Head/Neck
☐	☐	Headaches
		Type_____
☐	☐	Vision Problems/Loss
☐	☐	Contact Lenses
☐	☐	Ear Problems
		Respiratory
☐	☐	Chronic Cough
☐	☐	Shortness of breath
☐	☐	Smoking
☐	☐	Breathing problems
☐	☐	Asthma/Emphysema
		Cardiovascular
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Poor circulation
☐	☐	Heart disease
☐	☐	Phlebitis/Varicose veins
☐	☐	Stroke/TIA
☐	☐	Pacemaker?
		Skin
☐	☐	Skin conditions …
		Type: _____
☐	☐	Bruise easily
Yes	No	Any loss of sensation?
		Other Conditions
☐	☐	Difficult digestion
☐	☐	Constipation
☐	☐	Liver
☐	☐	Gall
☐	☐	Kidney
☐	☐	Bladder
☐	☐	Diabetes
☐	☐	Sinus:_____
☐	☐	Allergies:_____
☐	☐	Insomnia:_____
☐	☐	Cancer:_____
☐	☐	Arthritis? Where? _____
☐	☐	Dr. diagnosed?_____

Current	Previous	Infections
☐	☐	Herpes
☐	☐	Hepatitis
☐	☐	Plantar warts
☐	☐	TB
☐	☐	HIV/AIDS
☐	☐	Other:_____
		Women
☐	☐	Menstrual problems
		Painful?
☐	☐	Caesarian section or other
☐	☐	Gynecological conditions?
☐	☐	Gynecological surgery?
☐	☐	Pregnant? _____
		Due date: _____
☐	☐	Children? #_____
☐	☐	Menopausal Problems?
		_____

Current Pain or Stiffness	Previous Pain or Stiffness	Muscle/Joints
☐	☐	Neck
☐	☐	Low Back
☐	☐	Mid-Back
☐	☐	Upper Back
☐	☐	Shoulders
☐	☐	Leg: Left/Right
☐	☐	Knee: Left/Right
☐	☐	Other:

Current	Previous	Other Healthcare Tx?
☐	☐	Chiropractor
☐	☐	Physiotherapist
☐	☐	Psychotherapy
☐	☐	Massage Therapy
☐	☐	Naturopathic Doctor
☐	☐	Homeopathic Doctor
☐	☐	Optometrist

Surgeries:

Type: _____
Date: _____
(May continue on back of sheet)
Current Symptoms: _____
Injury Type: _____
Date: _____
Current Symptoms: _____

Current Medications:

Name	For What Condition?

Medical Doctor Information:

Name: _____
Address: _____
Date of Last Visit: _____
DD/MM/YY

Other Medical Conditions:

(i.e. pins, wires, artificial joints or limbs, Osteoporosis, etc)

_____
_____
_____
_____
_____

IMPORTANT: your massage therapy appointment has been reserved for you. If you are unable to keep your scheduled appointment, it is important to give 24 hours notice. Missed appointments: Clients will be charged full value for time missed.

Signature: _____ Date: _____

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