

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

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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: _____

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

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

Where did you first hear about the clinic? _____
Please be specific: eg: article, name of friend/doctor/association, 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	Current	Previous	Infections	Surgeries: Type: _____ Date: _____ Current Symptoms: _____ Injury Type: _____ Date: _____ Current Symptoms: _____																				
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Herpes																					
		Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis																					
<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Plantar warts																					
<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	TB																					
<input type="checkbox"/>	<input type="checkbox"/>	Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS																					
		Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____																					
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough			Women																					
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems																					
<input type="checkbox"/>	<input type="checkbox"/>	Smoking			Painful?																					
<input type="checkbox"/>	<input type="checkbox"/>	Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Caesarian section or other																					
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Gynecological conditions?																					
		Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Gynecological surgery?																					
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant? _____																					
<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure			Due date: _____																					
<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Children? # _____																					
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal Problems?																					
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/Varicose veins			_____																					
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA			_____																					
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker?			_____																					
		Skin	Current	Previous	Muscle/Joints	Current Medications: <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Name</td> <td style="width: 40%;">For What Condition?</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	Name	For What Condition?	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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<input type="checkbox"/>	<input type="checkbox"/>	Skin conditions ...	Pain or	Pain or	Neck																					
		Type: _____	Stiffness	Stiffness	Low Back																					
<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Mid-Back																					
Yes	No	Any loss of sensation?	<input type="checkbox"/>	<input type="checkbox"/>	Upper Back																					
		Other Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders																					
<input type="checkbox"/>	<input type="checkbox"/>	Difficult digestion	<input type="checkbox"/>	<input type="checkbox"/>	Leg: Left/Right																					
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Knee: Left/Right																					
<input type="checkbox"/>	<input type="checkbox"/>	Liver	<input type="checkbox"/>	<input type="checkbox"/>	Other:																					
<input type="checkbox"/>	<input type="checkbox"/>	Gall	<input type="checkbox"/>	<input type="checkbox"/>	_____																					
<input type="checkbox"/>	<input type="checkbox"/>	Kidney			_____																					
<input type="checkbox"/>	<input type="checkbox"/>	Bladder	Current	Previous	Other Healthcare Tx?																					
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Chiropractor																					
<input type="checkbox"/>	<input type="checkbox"/>	Sinus: _____	<input type="checkbox"/>	<input type="checkbox"/>	Physiotherapist																					
<input type="checkbox"/>	<input type="checkbox"/>	Allergies: _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychotherapy																					
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia: _____	<input type="checkbox"/>	<input type="checkbox"/>	Massage Therapy																					
<input type="checkbox"/>	<input type="checkbox"/>	Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>	Naturopathic Doctor																					
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis? Where? _____	<input type="checkbox"/>	<input type="checkbox"/>	Homeopathic Doctor																					
<input type="checkbox"/>	<input type="checkbox"/>	Dr. diagnosed? _____	<input type="checkbox"/>	<input type="checkbox"/>	Optometrist																					

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: _____