Kenaston Common
PHYSIOTHERAPY

Massage Therapy History Form

Patient Name____ Date of Birth_______________________

Please √ conditions you are currently experiencing or have experienced in the past.

- o heart conditions
- o circulatory conditions
- o respiratory conditions
- o headaches/migraines
- o fractures
- o osteoporosis
- o arthritis
- o disorders of the stomach or digestive tract
- o high/low blood pressure
- o fainting/dizziness
- o nervous system disorders
- o seizures
- o diabetes
- o strains/sprains
- o jaw problems
- o skin conditions/irritation
- o cancer
- o communicable disease
- o fibromyalgia
- o whiplash
- o infectious disease
- o athletes foot
- o Other______________________ ___________________________________

Are you currently being treated by any of the following?

- o Massage Therapist
- o Specialist_________________
- o Physiotherapist
- o Others___________________
- o Physician
- o Chiropractor

Are you currently taking any medication (prescribed or non prescribed)?____

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Occupation: ____

Recreational activities & interests: ____

Stress level (scale 1-10, 10 being high stress)____________

If you are a female, are you pregnant? __________________

Have you received a professional therapeutic massage before? _______________

Prioritize the areas of your body that you would prefer to be massaged___________________________________

The information on this form is true to the best of my knowledge.

Patient Signature____ Date ____