Amy Reed Welton, RMT

Registered Massage Therapy

HEALTH HISTORY

Name: -------------------- Date: ----/------/--
dd mm yyyy

Address: -------------------- Apt#: _________ _

City: ____________________ Prov: _____________ Postal Code: _____________

Phone Number: Home - -------------

Work - -------------

Date of Birth: _____/_______/_____ Occupation: -------------
dd mm yyyy

Height: ----------------

Family Doctor: ------------------------------

Phone: ---------- **Address:** -------------

Who referred you to this clinic? -----------------------

What brings you in for a massage treatment?

Primary concern: --------------------------

0ther concerns: --------------------------

Level of discomfort: [ ] mild [ ] moderate [ ] severe [ ] none

Type of pain: [ ] constant [ ] intermittent [ ] with certain movements
[ ] dull [ ] aching [ ] sharp [ ] tingling [ ] burning
[ ] refelTing [ ] other ________________________________

Did you have a specific injury? ____

Date: ----------------------------

Health Care: (please check all modalities you have used)

[ ] Massage therapy [ ] Chiropractic [ ] Naturopathy/Homeopathy

[ ] Physiotherapy [ ] Acupuncture [ ] Other: ________________________________

CONDITIONS:

Muscle & Joint
[ ] whiplash
date: ______________
[ ] arthritis OA or RA
[ ] bursitis
[ ] neck pain/stiffness
[ ] shoulder pain/stiffness
[ ] back pain/stiffness
upper / mid / low
[ ] hip pain/stiffness
[ ] knee pain/stiffness
[ ] ankle pain/stiffness
[ ] foot pain/fallen arches

Skin
[ ] rash
[ ] hives
[ ] bruise easily
[ ] acne/boils
[ ] oily/dry

Respiratory
[ ] chronic cough
[ ] shortness of breath
[ ] bronchitis
[ ] asthma - intrinsic
- extrinsic
[ ] emphysema
[ ] chest pain

Neurological
[ ] loss of sensation:
____
[ ] headaches
[ ] nervousness
[ ] depression
[ ] tremors
[ ] convulsions/epilepsy
[ ] dizziness
[ ] fainting

Cardiovascular
[ ] high blood pressure
[ ] low blood pressure
[ ] heart attack
[ ] stroke
[ ] rapid/slow heart beat
[ ] hardening of arteries
[ ] swelling of ankles
[ ] chest pain
[ ] poor circulation

ENT
[ ] vision problems
[ ] eye problems
[ ] hearing problems
[ ] ear problems
[ ] sinus infections
[ ] dental problems
[ ] enlarged glands

Gastrointestinal
[ ] irritable bowel
[ ] colitis
[ ] constipation
[ ] difficult digestion
[ ] stomach pain
[ ] gallbladder problems
[ ] nausea/vomiting
[ ] diarrhea

Woman
[ ] pregnant
[ ] PMS
[ ] endometriosis
[ ] other:
____

Infection
[ ] hepatitis
[ ] skin condition
[ ] tuberculosis
[ ] HIV/AIDS
[ ] other: ______________

Other
[ ] allergies:
____
[ ] diabetes
[ ] varicose veins
[ ] cancer

Current medications/supplements/ herbs:

Names and conditions treated: ______________________________

____

Previous injuries (including fractures, sprains, strains, dislocations):

Injury: ______________ Mechanism: ______________ Date: ______________

Injury: ______________ Mechanism: ______________ Date: ______________

Surgeries: Reason: ______________________ Date: ______________

Reason: ______________________ Date: ______________

Do you have any pins, wires, artificial limbs or pacemaker? ______________

____

Informed Consent

I understand that a complete and accurate health history is important to ensure that it is safe for me to receive massage treatment and will notify the therapist of any changes to my health. I understand that by signing this form, I give consent to receive the treatment in this and future appointments. I hereby give my consent for massage therapy treatment(s). All information obtained is strictly confidential except as required by law or by your written authorization. You may ask questions at any given time for better understanding of what the treatment(s) entails.

Signature: ______________________________ **Date:** ____________________

*** FOR CLINICAL USE - TO BE FILLED OUT BY MASSAGE THERAPIST ***

SUBJECTIVE:

OBJECTIVE:

GOALS OF TREATMENT:

ANALYSIS:

INITIAL TREATMENT PLAN:

TESTING:
- **[ ] postural analysis**
- **[ ] ROM testing**
- **[ ] orthopedic**
- **[ ] other**

Date: ____________ **Time:** ____________ **Duration:** ________ **Fee $:** ________

Informed consent received: **treatment** **assessment** **Therapist:** ____________________

Techniques used		Notes	Areas treated
stroking	mobilization	(include clinical findings; client reaction/feedback to treatment; recommended self-care; used and/or recommended remedial exercises; used and/or hydrotherapy; advice given)	back
rocking	low grade joint		neck
effleurage	stretch		shoulders
petrissage	intra-oral		face
friction	breast massage		arm L R
vibration	other (list)		leg L R
tapotement			gluteus
fascial			abdominals
myo-facial trigger			chest
point			breast
high grade joint			other (list)