Momentum Healing Arts Centre

Massage Therapy Health Information

1065 Canadian Place, Mississauga, Ontario. L4W 0C2 – 416-622-1939

Case History

I understand that the information that I give on this form will be confidential. Date:_____

Patient Name: _____

Patient Address:_____

City: _____ Postal Code:_____

Telephone: (day)_____Evening:_____
D.O.B. _____Wt:____Hgt:_____Occupation:_____

DOCTORS INFORMATION
Doctor' Name:_____

Doctor's Address: _____

_____

Doctors Phone #_____

How did you hear about our clinic? (Be specific; eg. Flyer, article, name of friend)_____

1. General Health (please describe)
   _____
   _____
   _____
2. Primary Complaint_____
3. What type of pain? (circle) dull, sharp, local, wide spread, shooting, throbbing.
4. Other areas of pain or concern?_____
   _____
5. When did you first notice major complaint?_____
6. What brought it on?_____
7. What activities aggravate the condition?_____
8. Is this condition getting progressively worse? Yes No Constant Comes & goes
9. Is this condition interfering with you work?_____ Sleep?_____ Daily Routine?_____
10. What do you believe is the source of the problem?_____
11. What have you done to get relief?_____
12. Has there been a medical diagnosis? If yes, what was the diagnosis?_____
    _____
    Name of Diagnosing Doctor:_____
    X-rays:_____Medication for above condition._____
13. Have you had a similar problem before? If yes, When?_____
    What caused those episodes?_____What relieved them?_____
    Previous presentation and treatment:_____
    Name of attending physician:_____Phone#_____
    Address:_____
14. Do you currently take medications for any condition Yes No
    If yes, please list them and indicate what they are for:_____
15. Have you had any traumatic injuries (i.e. car accidents, falls, etc.)? If yes, please explain._____

_____
_____

HEALTH HISTORY

Please check any of the symptoms you are experiencing and add any not mentioned which are significant to you. Sometimes a symptom, which seems trivial, can supply a key to providing relief.

HEAD
- Headaches:
  - Type:_____
  - Frequency:_____
- Injury (head)

Details:_____
_____
- Vertigo
- Vision loss
- Earache
- Jaw pain/TMJ dysfunction
- Sinus
- Hearing loss
- Other_____

_____

RESPIRATORY
- Chronic Bronchitis
- Tuberculosis
- Frequent Colds
- Chronic Cough
- Shortness of breath
- Sinusitis
- Asthma emphysema
- CCHF
- Other_____

_____

WOMEN
- Menstrual Problems
  - Painful
  - Heavy
  - Light
- Pregnant/Due date_____
- No. of children _____
- History of miscarriage_____
- Menopause
- Hysterectomy
- Breast cancer
- Other_____

SKIN
- Rashes
- Sores
- Itching
- Dryness
- Herpes
- Eczema
- Psoriasis
- Cold sores
- Scars
- Other_____

_____

NEUROLOGICAL
- Fainting spells
- Blackouts
- Seizures
- Paralysis
- Weakness
- Numbness
- Tingling
- Tremors
- Loss of sensation
  - Where?_____
- Other_____

_____

CARDIAC
- Presence of pace maker
- Heart disease
- High blood pressure
  - How long?_____
- Low blood pressure
- Heart attack
- Stroke/CVA
- Heart murmur
- Angina
- Other_____

DIGESTIVE/ UROGENTIAL
- Poor appetite
- Constipation
- Crohn's Disease
- Kidney/bladder/liver/
- Gallbladder disease
- Difficult digestion
- Diabetes
  - Onset:_____
  - Type:_____
- IBS
- Colitis
- Other_____

_____

VASCULATURE
- Leg cramps
- Varicose veins
- Poor circulation
- Phlebitis
- Raynaud's syndrome
- Atherosclerosis
- Other_____

_____

ARTHRITIS
- Rheumatoid
- Osteoarthritis
- Systemic Lupus Erythmatosus
- Psoriatic
- Reiter's disease

When diagnosed?_____
List affected areas:
- Family History

_____
- Other_____

MUSCLE/JOINTS

	Stiffness	Current pain/ stiffness	Previous pain/
Neck			
Low back			
Mid back			
Upper back			
Shoulders			
Leg: left/right			
Knee: left/right			
Other:_____			

OTHER CONDITIONS

Insomnia
Cancer
Epilepsy: What type? _____
HIV+ How Long? _____
Allergies
Thyroid Imbalance
Hepatitis B, C (circle)
Psychological:
Hemophilia
Infectious Skin Conditions
Osteoporosis

Presence of:

Pins
Wires
Artificial joints
Special equipment
Screws
Plates

Other_____

CURRENT INVOLVEMENT IN TREATMENT WITH OTHER PRACTICTIONER (S)

	Yes	No
Chiropractic		
Psychotherapy		
Personal Trainer		
Physiotherapy		
Previous massage		
Acupuncture		
Naturopathic/homeopathy		
Osteopathy		
Good sleeping patterns		
Regular eating habits		
Other_____		

SURGERY

Type:_____Date:_____

OTHER MEDICAL CONDITIONS: