Momentum Healing Arts Centre

Massage Therapy Health Information

1065 Canadian Place, Unit 101, 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 #_____

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	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:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____