PARRY SOUND MASSAGE THERAPY CLINIC
89 Bowes Street, Parry Sound, Ontario
Telephone (705) 746-4660

CASE HISTORY OUTLINE

Name: _____

Address: _____
Postal Code

Telephone: _____ _____ _____ Occupation: _____
Home Work Cell

Date of Birth: _____ Weight: _____ Height: _____

Where did you hear about the Clinic? _____
Please be specific: e.g paper, name of friend, name of doctor, etc...

What brings you in for a massage? _____

_____

How would you describe your general health? _____

Health History: Please check the conditions that you are currently experiencing, or have experienced often in the past.

Current/Previous

Head/Neck
- ☐ ☐ Headache type_____
- ☐ ☐ Vision problems
- ☐ ☐ Contact lenses
- ☐ ☐ Earaches

Respiratory
- ☐ ☐ Chronic cough
- ☐ ☐ Shortness of breath
- ☐ ☐ Smoking
- ☐ ☐ Breathing problems type_____

Cardiovascular
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Poor circulation
- ☐ ☐ Heart disease
- ☐ ☐ Phlebitis
- ☐ ☐ Stroke
- ☐ ☐ Vericose veins Dr. Diagnosed? _____

Current/Previous

Skin
- ☐ ☐ Skin conditions type_____
- ☐ ☐ Bruise easily

Other Conditions
- ☐ ☐ Numbness or Tingling
- ☐ ☐ Difficult digestion
- ☐ ☐ Constipation
- ☐ ☐ Liver_____
- ☐ ☐ Gall bladder_____
- ☐ ☐ Kidney_____
- ☐ ☐ Bladder_____
- ☐ ☐ Diabetes, onset_____
- ☐ ☐ Sinus
- ☐ ☐ Allergies_____
- ☐ ☐ Insomnia
- ☐ ☐ Epilepsy
- ☐ ☐ Cancer_____
- ☐ ☐ Arthritis_____
- ☐ ☐ Dr. diagnosed? _____ affected areas_____

Current/Previous

Infections
- ☐ ☐ Herpes
- ☐ ☐ Hepatitis
- ☐ ☐ Plantar warts
- ☐ ☐ TB
- ☐ ☐ HIV, AIDS
- ☐ ☐ Other_____

Current/Previous

Women
- ☐ ☐ Menstrual problems ☐ painful
- ☐ ☐ Caesarian section, or other
- ☐ ☐ Gyneocological surgery_____ _____
- ☐ ☐ Pregnant: due date _____
- ☐ ☐ Menopausal problems _____ _____
- ☐ ☐ Children: number_____

Current/Previous

Other Healthcare
- ☐ ☐ Chiropractic
- ☐ ☐ Physiotherapy
- ☐ ☐ Psychotherapy
- ☐ ☐ Regular exercise
- ☐ ☐ Massage

Surgery
type_____
date_____
current symptoms_____
_____

Injury
type_____
date_____
current symptoms_____
_____

Insurance Coverage
Company Name _____

Is there a family history of arthritis?
☐ Yes ☐ No

Current Medications

Name	For what condition
_____	_____
_____	_____
_____	_____
_____	_____

Medical Doctor
Name_____
Phone_____
Date of last visit_____

Muscles
Current Pain/Stiffness / Previous Pain/Stiffness

Neck	☐	☐
Low Back	☐	☐
Mid-Back	☐	☐
Upper Back	☐	☐
Shoulders	☐	☐
Leg: Left/Right	☐	☐
Knee: Left/Right	☐	☐
Other_____	☐	☐

Is there a family history of any of the conditions above? ☐ No ☐ Yes _____

OTHER MEDICAL CONDITIONS? _____

OF SPECIAL NOTE: (pins, wires, artificial joints or limbs, special equipment such as wheelchairs, walkers, cane, etc)

_____

Please turn the page over

CONFIDENTIALITY AGREEMENT

I understand that the information that I give on this form will be confidential and will be used for no other purpose than the professional therapist's clinical records. This information is required to comply with the legislation which governs Massage Therapy in Ontario.

24 HOUR CANCELLATION POLICY

I understand that if I miss a massage appointment completely I will be charged the full amount of the time I have missed.

I understand that if I do not have a valid excuse for cancelling within the 24 hours of treatment I will be charged the full amount of the time I have missed.

I understand that if I arrive late for an appointment that I will be charged the full amount of the scheduled appointment time.

I understand that a massage therapist's time is valuable, and goes unpaid if I miss my scheduled appointment without leaving time for the treatment time to be rebooked.

I understand that someone else may have wanted the time slot that I booked.

I understand all that has been stated above and will give the massage therapist 24 hours notice before cancelling a massage appointment or I will be charged the full amount of the missed treatment time.

Sign_____ Date_____