WASCANA REMEDIAL MASSAGE CENTRE

Confidential Patient Case History

Name_____

Address_____Postal Code_____

E-Mail Address_____

(Your E-Mail Address is strictly for the use of this Clinic and will not be shared or sold)

How Did You Hear About Our Clinic: _____

Home Phone #: _____ Work #: _____ Other #: _____

Employer: _____ Position: _____

Male / Female Birth Date: _____ Age: _____ Height: _____ Weight: _____

Married / Single Spouse's Name: _____ # of Children _____

Spouse's Employer: _____ Ages of Children: _____

_____

Comments / Notes of Caution

_____

_____

_____

_____

Hobbies: _____

_____

Recreation: _____

_____

Chief Complaint: _____

_____

Initial Onset: _____

Probable Cause: _____

Acute / Chronic

Exercise

Heavy / Moderate / Light / None

Water Consumption

Heavy / Moderate / Light / None

_____

Have you ever had massage before? YES NO Where? _____

Date of last treatment: _____

Patient's Comments: _____

What are your goals and expectations from this session? _____

_____

Who is your Family Doctor? _____

Date of last visit: _____

Patient's Comments: _____

Who is your Chiropractor? _____

Date of last visit: _____

Patient's Comments: _____

Have you been for any of the following treatments in the last 12 months?

Physiotherapy	YES	NO	Conditioning Therapy	YES	NO
Reflexology	YES	NO	Acupuncture	YES	NO

1. Have you had any serious falls, accidents or injuries in the past 3 years? YES NO

   Explain: _____

   _____

2. Have you had surgery in the past 3 years? YES NO

   Explain: _____

   _____

3. Have you been in a motor vehicle accident in the past 10 years? YES NO

   Dates: _____

4. Do you have any sleep problems? YES NO

   Cause: _____

5. Is your Blood Pressure: Normal High Low Stable Erratic

6. Have you ever been ***treated for?*** ***If YES, please explain***

any psychological or emotional health issues	YES	NO	_____
thyroid problems	YES	NO	_____
ulcers	YES	NO	_____
heart disease	YES	NO	_____
lung disease	YES	NO	_____
cancer	YES	NO	_____
diabetes	YES	NO	_____
HIV / Immune Deficiency	YES	NO	_____
alcoholism / substance abuse	YES	NO	_____
arthritis	YES	NO	_____
fibromyalgia	YES	NO	_____
liver disorder / hepatitis	YES	NO	_____
blood clots / varicose veins	YES	NO	_____
TMJ	YES	NO	_____
headaches / dizziness	YES	NO	_____ SEE PAGE 3 _____
other	YES	NO	_____

7. Please circle:

Coffee:	How many cups per day	None	1 – 3	3 – 5	5 – 10	More
Smoking:	How many packs per day	None	> ½ pkg	½ pkg	full pkg	More
Alcohol:	How many drinks per week	None	1 – 3	3 – 5	5 – 10	More

This is to acknowledge my wish to consent to receive massage therapy treatments, as outlined to me.
I understand that I may withdraw consent at anytime and that treatment will then be stopped.
The information contained on this form is true to the best of my knowledge.

Signature: _____ Date: _____

Headache History

Headaches: How often do you get them? _____

How long do they last? _____

What causes your headaches? _____

What do you take to control them? _____

Migraine: YES NO Initial Onset Date: _____

Trigger: _____

Current Medications
(Over the Counter & Prescription)

Medication: _____ For what condition: _____

How many times per day: _____ Date started: _____

Medication: _____ For what condition: _____

How many times per day: _____ Date started: _____

Medication: _____ For what condition: _____

How many times per day: _____ Date started: _____

Medication: _____ For what condition: _____

How many times per day: _____ Date started: _____

Medication: _____ For what condition: _____

How many times per day: _____ Date started: _____

Medication: _____ For what condition: _____

How many times per day: _____ Date started: _____

Medication: _____ For what condition: _____

How many times per day: _____ Date started: _____

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

Signature: _____ Date: _____

Our Association (Massage Therapist Association of Saskatchewan, Inc.) requires that you read the following. If there is any part of this document that you do not agree with, cross it out and place your initials beside it.

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Massage Therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of Saskatchewan, Inc.

I hereby consent to my Therapist to treat me with Massage Therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my Therapist.

I acknowledge that the Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that Massage Therapy is not a substitute for a medical examination. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Therapist must be fully aware of my existing medical conditions. I have completed my medical history form, as provided by my Therapist, and have disclosed to the Therapist all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my Therapist to release or obtain information pertaining to my condition(s) and / or treatment to / from my other caregivers or third party payers.

I have read the above noted consent and have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my Therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name	Signature of Patient or Guardian
Witness	Date Signed