Client Medical History

I understand that the information that I give on this form will be confidential and will only be released with your written consent.

Name:_____ **Date:**_____
Address:_____ **Date of Birth:**_____
_____ **Home Phone:**_____
Postal Code:_____ **Work Phone:**_____
Occupation:_____ **Cell Phone:** _____
Physician's Name:_____ **Email Address:**_____
Please list previous surgery, injuries or illnesses:_____
_____

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

Head/Neck	current/previous	**Skin**	current/previous
Headaches	____/____	skin conditions	____/____
Type _____	____/____	type_____	____/____
Vision problems	____/____	bruise easily	____/____
Contact lenses	____/____		
Ear aches	____/____		
Women		**Respiratory**	
Menstrual problems	____/____	chronic cough	____/____
Cesarean section or other Gynecological surgery	/____	shortness of breath	____/____
Pregnant: due date_____		smoking	____/____
Menopausal problems	____/____	breathing problems	____/____
		Type_____	
Cardiovascular			
High blood pressure	____/____	**Infections**	
Low blood pressure	____/____	herpes	____/____
Poor circulation	____/____	hepatitis	____/____
Heart disease	____/____	plantar warts	____/____
Phlebitis	____/____	TB	____/____
Varicose veins	____/____	HIV	____/____
Dr. diagnosed?	_____	Other	____/____
		Other Conditions	
Difficult digestion	____/____	constipation	____/____
Liver	____/____	gall bladder	____/____
Kidney	____/____	bladder	____/____
Diabetes	____/____	sinus/allergies	____/____
Insomnia	____/____	arthritis	____/____
Cancer	____/____	affected areas	_____

Muscles	current pain /stiffness	previous pain/stiffness
Neck	_____	_____
Low back	_____	_____
Mid back	_____	_____
Upper back	_____	_____
Shoulders	_____	_____
Leg: left/right	_____	_____
Knee: left/right	_____	_____
Other	_____	

Other Healthcare	current/previous
Chiropractic	_____/_____
Physiotherapy	_____/_____
Regular exercise	_____/_____
Massage	_____/_____
Acupuncture	_____/_____

Current Medications	
Name	for what condition
_____	_____
_____	_____
_____	_____
_____	_____

Informed Consent

I understand that the purpose of massage is for relief of pain, spasms, muscle tension, for increasing circulation and rehabilitation, and for stress reduction. I am aware that the massage therapist does not diagnose illnesses, disease, or any other mental or physical disorders. It is also my knowledge that the massage therapist does not prescribe medical treatments or prescriptions for pharmacy, nor do they do spinal adjustments. I also understand that the massage therapist is no substitute for medical examinations or diagnoses and that it is recommended that I see another healthcare practitioner for such matters.
I have stated all my known medical conditions and will keep the massage therapist updated on my physical health.

_____ _____

Signature **Date**

_____ _____

Jeannette Raskin R.M.T. **Date**