FAITH
PHYSIOTHERAPY

Valley Creek Plaza Unit C5
1965 Cottrelle Blvd
Brampton, ON - L6P 2Z8
(905) 794-3435
faithphysiomassage@gmail.com

MASSAGE CASE HISTORY

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone: _____

Address: _____

Occupation: _____ Date of Birth: _____

Have you received massage therapy before? ☐ Yes ☐ No

Did a healthcare practitioner refer you for massage therapy? ☐ Yes ☐ No

If yes please provide their name and address: _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

☐ high blood pressure
☐ low blood pressure
☐ chronic congestive heart failure
☐ heart attack
☐ phlebitis / varicose veins
☐ stroke / CVA
☐ pacemaker or similar device
☐ heart disease

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

Respiratory

☐ Chronic Cough
☐ Shortness of breath
☐ Bronchitis
☐ Asthma
☐ Emphysema

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

Infections

☐ hepatitis
☐ skin conditions
☐ TB
☐ HIV
☐ herpes

Other Conditions

☐ loss of sensation, where? _____
_____
☐ diabetes, onset: _____
☐ allergies/hypersensitivity to what?
_____
type of reaction:
☐ Epilepsy
☐ Cancer, Where? _____
_____
☐ Skin Conditions, What?
_____
☐ Arthritis

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

Head/Neck

☐ history of headaches
☐ history of migraines
☐ Vision problems
☐ Vision loss
☐ ear problems
☐ hearing loss

Women

☐ Pregnant, due _____
☐ gynaecological conditions,
What? _____

Overall, how is your general health?
_____

Primary Care Physician:
_____
Address:
_____
_____

Current Medications: _____
_____
condition it treats: _____
_____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what? _____
_____

Surgery - date _____
nature: _____

Injury - date _____
nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) ☐ Yes ☐ No
What? _____

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No
What? _____
Where? _____

What is the reason you are seeking massage therapy? Please indicate the location of any tissue or joint discomfort. _____
_____

Notes:

Date of Initial History: _____
Update 1: _____
Update 2: _____
Update 3: _____

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CONSENT TO MASSAGE TREATMENT

I hereby consent to the treatments for the following complaints:

_____

_____

_____

_____

The therapists have provided me with information relevant to treatments for the above listed complaints.

Alternative courses of treatments where applicable and relevant as well as the possible risks and side effects of my therapists' proposed treatment plan that have been explained to me.

The consequence of having treatments/ not having treatments have been explained to me. I have been informed that I may stop treatments at any time.

At any time throughout the treatments, I may request the therapist to stop, modify or change the treatment plan.

I have read the above and understand the consent to massage treatment.

READ BEFORE SIGNING

_____
Name (Please Print)

_____ Date: _____
Signature of Patient (or Legal Guardian)

_____ Date: _____
Signature of Witness

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CONSENT FOR ASSESSMENT AND TREATMENT OF SENSITIVE AREAS

I, _____(name), have requested assessment and/or treatment by this Registered Massage Therapist (RMT) _____(name) for treatment of the clinically relevant areas indicated below (please initial):

__ Buttocks (gluteal muscles)

Chest Wall Muscles

__ Upper Inner Thigh(s)

--- Breast (s)

The RMT has explained the following to me and I fully understand the proposed assessment and/or treatment:

- The nature of the assessment, including the clinical reason(s) for assessment of the above area(s) and the draping methods to be used
- The expected benefits of the assessment
- The potential risks of the assessment
  The potential side effects of the assessment
- That consent is voluntary
- That I can withdraw or alter my consent at any time

I voluntarily give my informed consent for the assessment and/or treatment as discussed and outlined above.

Client Name (print): _____

Client Signature: _____ Date: _____

Ongoing Treatment:

I am aware that the treatment of the above indicated area(s) is part of a treatment plan which has been discussed with me by my RMT. I confirm that, on the following date(s), the RMT has reviewed the treatment plan and I provide my informed consent.

Client Signature: _____ Date: _____

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Blood Pressure:

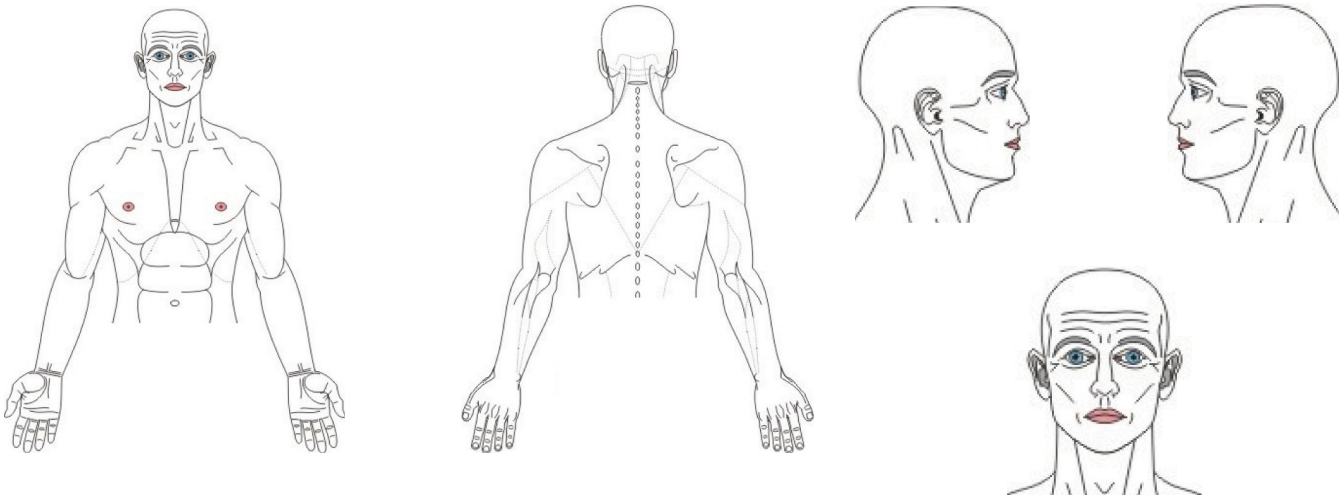
MASSAGE INITIAL ASSESSMENT

Name: _____ Date: _____

DOL: _____ X-rays: Y ☐ N ☐ Px Meds: Y ☐ N ☐

1° Complaint: _____

CERVICAL/THORACIC/UPPER EXTREMITIES



Onset of Px
Duration
Aggravating Factor
Radiation

Quality of Px
Intensity
Relieving Factor
Associated Symptoms

A-ROM:
Flexion
Extension
Rotation (R)
Rotation (L)
Lat. Flex (R)
Lat. Flex (L)

P-ROM
Flexion
Extension
Rotation (R)
Rotation (L)
Lat. Flex (R)
Lat. Flex (L)

Orthopedic Testing:
Compression: Localized
Referring
Quadrant: R L
Adson's
Eden's
Wright's

Notes: _____

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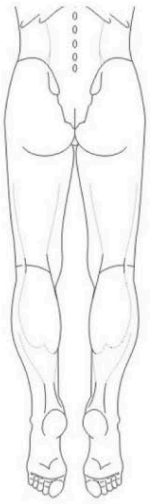
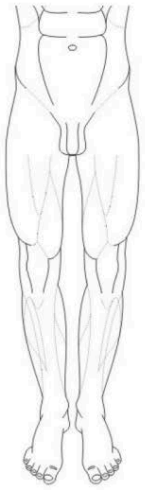
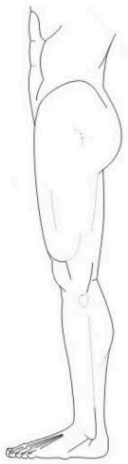
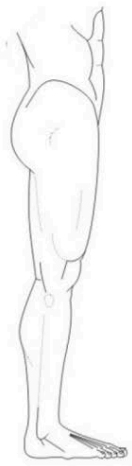
Patient Name: _____ Date: _____

LUMBAR/LOWER EXTREMITIES

Onset of Px
Duration
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Quality of Px
Intensity
Relieving Factor
Associated Symptoms

A-ROM:
Flexion
Extension
Rotation (R)
Rotation (L)
Lat. Flex (R)
Lat. Flex (L)

Orthopedic Testing:
SLR: R L
Gaenslen
Pelvic Rocking
Fabere
Thomas
Trendelenberg

Notes: _____

TREATMENT PLAN: _____

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MASSAGE PROGRESS NOTES

Important clinical note:

PATIENT'S NAME _____

Date:	Time: ampm	Duration: min/hr	Fee $
Informed consent received:	Treatment Assessment	Therapist:	

Techniques Used:	Notes: (Include Clinical Findings, Client Reaction/feedback to treatment; recommended self-care; used and/or recommended remedial exercises; used and/or hydrotherapy; advice given)	Areas Treated:
stroking		back
rocking		neck
compressions		shoulders
effleurage		face
petrissage		arm L R
mobilization		leg L R
vibration		gluteus
tapotement		abdominals
fascial		chest
trigger point		breast
joint play		other (list)
stretch		
other (list)		

Date:	Time: ampm	Duration: min/hr	Fee $
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