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: _____

FAITH
PHYSIOTHERAPY

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

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