Dundas Massage Therapy a Division of Dundas Chiropractic Centre
360 Dundas Street East, Unit B4, Oakville, Ontario L6H 6Z9 (905) 257 - 5628

CASE HISTORY FORM

Name:_____Date:_____

Address:_____ Telephone: Home_____ Business _____
City/Town Postal Code

Date of Birth:_____ Weight:_____ Height:_____ Medical Doctor:_____ Phone No: _____

Email Address:_____Occupation:_____

Where did you first hear about our office:_____ What brings you in for a massage? _____

PRIMARY INSURANCE

Max Massage Therapy Coverage: $_____

Insurance Year End:_____

SECONDARY INSURANCE

Max Massage Therapy Coverage: $_____

Insurance Year End:_____

OTHER SERVICE EXTENDED HEALTH INSURANCE COVERAGE

Chiropractic

Chiropractic Coverage: $_____
Insurance Year End:_____

Chiropody (Orthotics)

Chiropody (Foot Care) Coverage: $_____
Insurance Year End:_____

Acupuncture

Acupuncture Coverage: $_____
Insurance Year End:_____

HEALTH HISTORY: Please check the conditions that you experience frequently:

HEAD/NECK:

Headaches _____ Epilepsy _____
Type:_____ Sinus _____
Vision problems _____ Frequent colds _____
Contact lenses _____ Neck pain _____
Ear aches _____

RESPIRATORY:

Chronic cough _____ Asthma _____
Smoking _____ Heavy _____ Light_____

CARDIOVASCULAR:

High Blood Pressure _____ Heart Disease _____
Low Blood Pressure _____ Shortness of Breath _____
Poor circulation _____

SKIN:

Sensitive skin _____ Phlebitis _____
Rashes/Eruption _____ Bruise Easily _____
Cold Sore _____ Varicose Veins _____
Herpes _____ Doctor Diagnosed _____

Allergies _____ _____ ____

WOMEN: MENSTRUATION:

Painful _____ Pregnant– due date:_____
Heavy _____ Number of Children:_____
Scant _____ Menopause ____

MUSCLES/JOINTS:

Pain _____ Back pain _____
Stiffness _____ Shoulder pain _____
Swelling _____ Neck pain _____
Limitation of movement _____
Rheumatoid arthritis: date Dx: _____
Osteoarthritis: date Dx: _____
effected areas: _____

DIGESTIVE/URO-GENITAL:

Poor appetite _____ Diarrhea _____
Kidney/Bladder _____ Crohns/ Irritable Bowel _____
Constipation _____ Difficult Digestion _____
Liver/Gall Bladder _____ Diabetes _____

SURGERY/INJURY:

Type: _____
Date:_____
Current Symptoms:_____

OTHER HEALTH CARE:_____

CURRENT MEDICATIONS AND CONDITIONS TREATED:

_____
_____
_____

Chiropractic Care: Yes _____ No _____

Previous Massage Experience Yes _____ No _____

Regular Exercise Yes _____ No _____

Psychotherapy: Yes_____ No _____

Good Sleeping Patterns: Yes _____ No _____

Regular Eating Habits: Yes _____ No _____

Do you have any of the following?

Pins ____ Wires _____ Artificial Joints _____ Artificial Limbs _____

Other Medical conditions? _____

Have you ever been involved in a motor vehicle accident? Yes _____ No _____
If so, when? 0-2 months ago _____ 2-6 months ago _____ Over 6 months ago _____

Is there anything else that we should know about you?

_____
_____
_____

- It is my choice to receive massage therapy treatment and it is my understanding that the information I have provided is confidential, except as required or allowed by law or to help facilitate treatment. I will be asked to provide written authorization for release of any information.
- I agree to communicate with my massage therapist anytime I feel that my well-being is compromised, and I acknowledge that I may cease the treatment at any point without reason.
- I am aware that it is not necessary to remove all articles of clothing for treatment and I will remove the clothing I am comfortable with.
- I am aware that I may experience possible side effects from the massage treatments such as temporary muscle discomfort (24-48 hours post-treatment), bruising, headache, or dizziness.
- Required to have written consent for every year.

_____ _____
Patient Signature Date

This form is recognized by the College of Massage Therapists of Ontario to contain the elements necessary to ensure compliance with the Standards of Practice.

All appointments may be cancelled without charge by giving 24 hours prior notice.

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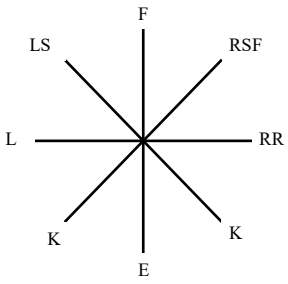
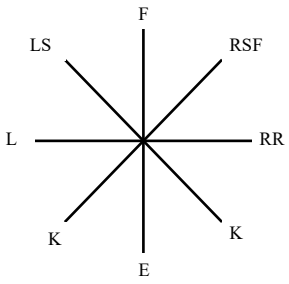


Dundas Massage Therapy

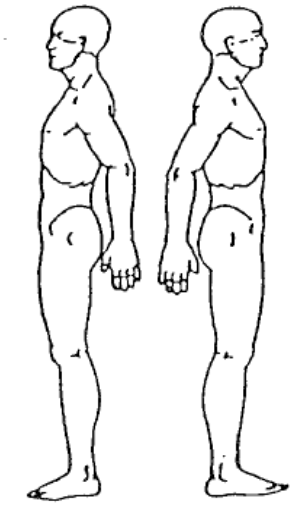


ONGOING CASE HISTORY FOR_____

Date / / RMT:_____Tx Time:_____

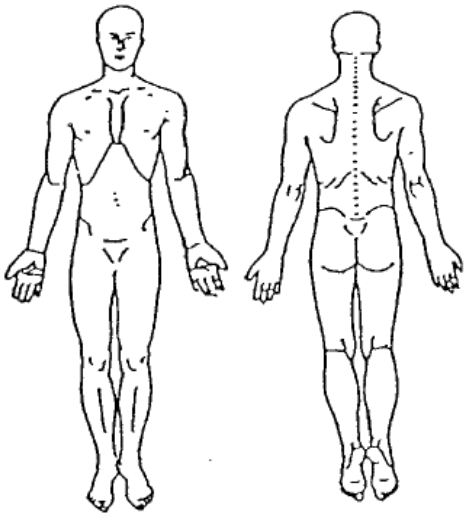
CLIENTS PRIORITIES

ASSESSMENT



TREATMENT

SELF CARE



NEXT TX RECOMMENDATIONS

Date / / RMT:_____Tx Time:_____

CLIENTS PRIORITIES

ASSESSMENT

TREATMENT

SELF CARE

NEXT TX RECOMMENDATIONS