Massage Therapy Medical History

Please Complete All 4 Pages

Name: _____

Date of birth: _____

Address: _____

Phone (H): _____

(W): _____

(C): _____

Email: * _____

Occupation: _____

Referred by: _____

Sask Health Card # _____

***Please provide your email.** Our system sends out an appointment reminder 24 hours prior to your appointment to avoid missed appointments and to confirm the appointment time. **We will ONLY use your email for reminders and office communication.**

Have you seen any of the following? (Please check all that apply)

		Name of professional	Reason for visit
Medical Doctor	_____	_____	_____
Massage Therapist	_____	_____	_____
Chiropractor	_____	_____	_____
Physiotherapist	_____	_____	_____
Reflexologist	_____	_____	_____
Acupuncturist	_____	_____	_____

Are you under any medical supervision? **YES** **NO** If yes, explain.

_____

Are you taking any medications or supplements? **YES** **NO** If yes, what kind(s)?

_____

Are you currently pregnant? **YES** **NO** If yes, how far along? _____

Have you ever had surgery, been in a car accident or had an injury from work, contact sports, falling or from overuse? **YES** **NO** If yes, please list **all** injuries and dates.

_____

_____

(Please continue on other side)

Is this visit part of a Workers Compensation claim, SGI injury claim or are you an RCMP member?

If yes, circle and provide claim number below.

SGI WCB RCMP VAC

SGI Injury Claim Number: _____

WCB Injury Claim Number: _____

RCMP R Number/ VAC K Number: _____

Please check if you have/had any of the following conditions.

Cancer	_____	Stroke	_____
Diabetes	_____	Allergies, asthma	_____
Epilepsy	_____	Parkinson's Disease	_____
HIV/AIDS	_____	Arthritis	_____
Multiple Sclerosis	_____	Varicose veins, blood clots	_____
High or low blood pressure	_____	Heart disease	_____
Skin infection or rash	_____	Digestive problems	_____
Fibromyalgia	_____	Osteoporosis	_____

List any other conditions not mentioned above.

_____

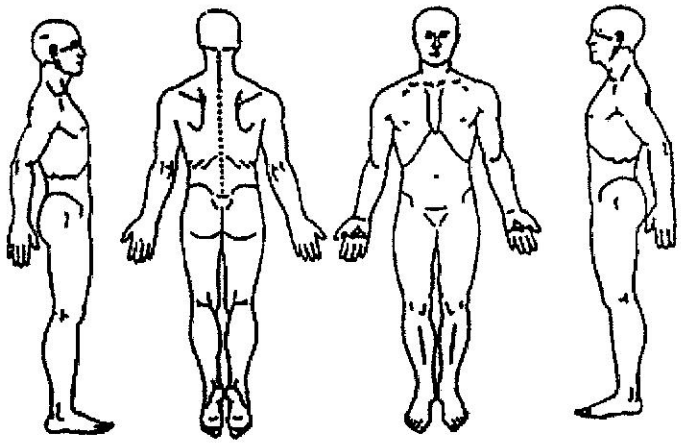
_____

What type(s) of physical activity/exercise do you participate in on a weekly basis?

_____

_____

Please mark the problems areas with an "X".



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ALL INFORMATION IS CONFIDENTIAL. Please inform your therapist of any changes to this information.

Signature: _____ Date: _____