



**Personal History**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Business Employer: \_\_\_\_\_  
Business Phone: \_\_\_\_\_  
Who may we thank for referring you to us? \_\_\_\_\_

**Current Health Condition**

Current Complaint(s): \_\_\_\_\_  
Have you seen your doctor for this condition? Y \_\_\_ N \_\_\_ Results: \_\_\_\_\_  
When did this condition begin? \_\_\_\_\_ Has this occurred before? Y \_\_\_ N \_\_\_  
Is this:  Job related  Auto related  Home injury  Sport related  Other: \_\_\_\_\_  
Aggravating Factors: \_\_\_\_\_  
Relieving Factors: \_\_\_\_\_

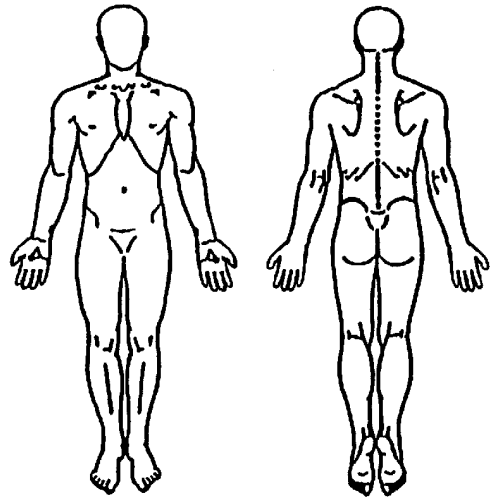
Is it getting:  Worse  Constant  Comes/Goes  Better  
Describe pain/symptoms:  Sharp  Dull  Ache  Pins & Needles  Numb  Burning  
 Throbbing Other: \_\_\_\_\_  
Circle to indicate the severity of your pain:  
*Least* 1    2    3    4    5    6    7    8    9    10 *Worst*  
Does this problem affect:  Work  Daily Activities  Family/Social  Sports/Hobbies  
If you do not get this problem corrected do you think it will get worse over the next few:  
 Weeks  Months  Years  Other: \_\_\_\_\_  
Medication/Drugs you take now: \_\_\_\_\_  
Rate your commitment to correcting this problem on a scale from 1-10, 10 being the highest \_\_\_\_\_

**Past Health History**

Major Surgeries: \_\_\_\_\_  
Major Injuries: \_\_\_\_\_  
Other Injuries/Dysfunction: \_\_\_\_\_

**Mark areas where you feel the described sensations.**

Aching           XXXXXXXXXXXXXXXXXX  
Burning           ~~~~~  
Pins/Needles    .....  
Numbness        #####  
Stabbing         ////////////////////  
Other:           \_\_\_\_\_  
                  \_\_\_\_\_  
                  \_\_\_\_\_  
                  \_\_\_\_\_  
                  \_\_\_\_\_





Check the appropriate box for any of the following symptoms which you have or have had previously.

**O** = Occasional

**F** = Frequent

**C** = Constant

**O F C**  
**Nervous System**

- Cold/Tingling Extremities
- Convulsions
- Dizziness
- Fainting
- Nervousness
- Depression
- Neuralgia
- Numbness

**Muscle & Joint**

- Arthritis
- Bursitis
- Foot Trouble
- Hemia
- Low Back Pain
- Neck Pain
- Neck Stiffness
- Pain Between Shoulders
- Tendinitis
- Hip/Knee/Ankle Pain
- Arm/Hand Pain

**C-V-R**

- Chest Pain
- Chronic Cough
- Difficulty Breathing
- Wheezing
- Blood Pressure Problems
- Heart Problems
- Stroke
- Varicose veins

**Eyes, Ears, Nose & Throat**

- Asthma
- Colds
- Vision Problems
- Hearing Difficulty
- Ear Aches
- Nasal Obstruction
- Sinus Infection

**General**

- Fatigue
- Loss of Sleep
- Allergies
- Fever
- Headaches
- Stress

**O F C**  
**Gastro-Intestinal**

- Poor/Excessive Hunger
- Excessive Thirst
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Weight Problems
- Abdominal Cramps
- Heartburn/Reflux

**Female**

- Menstrual Irregularity
- Menstrual Cramping

Pregnant:  Yes  No

Due Date: \_\_\_\_\_

**Intake**

- Alcohol
- Coffee
- Tea
- Cigarettes
- White Sugar
- Recreational Drugs
- Performance Enhancing Drugs

**Check if you have or have had any of the following?**

- Aneurysm
- Cancer
- Pneumonia
- S.T.D
- Osteoporosis
- Polio
- Psoriasis
- Diabetes
- Epilepsy
- H.I.V
- Influenza
- Chicken Pox
- Mental Disorder
- Eczema

**Do you have an exercise program?**

Yes  No

Sports/activities involved in: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Why Massage Therapy / Sports Injury Therapy?**

- Preventative/Progressive > Life enhancement and wellness care, athletic/health potential
- Corrective Care > Removing cause and remodeling soft tissue
- Relief Care > Band-aid care only
- Check here if you want your therapist to select the type of care appropriate for your condition

**Informed Consent**

*Assessment*

The purpose of an assessment is to better understand what elements are involved a given case so that treatment can be effective. The assessment will include asking for you, the patient, to move into different positions and the therapist physically moving you into positions. Testing will be bilaterally (both sides). Your symptoms and/or pain may return, if this happens describe what you are feeling. Painful tests will be done within your comfort. Time will be given for you to change into appropriate clothing. You may alter or discontinue the assessment at anytime and are encouraged to ask any questions you may have.

*Treatment*

The only areas that will be treated or exposed will be the ones discussed in the assessment. If you wish to change the treatment in anyway let the therapist know and they will change accordingly. This includes areas being treated, duration, modalities etc. You may feel some soreness for 24 to 48 hours after. You may also feel dizzy or nauseous when getting off the table so take your time. You will be provided time to change clothing before and after the treatment. Clothing can be left on if desired however skin contact allows for a more effective treatment. If you need assistance on the table please discuss this just prior to getting on the table. You can change or discontinue the treatment at anytime and are encouraged to ask any questions you have.

If you feel uncomfortable at all during any part of a given assessment/treatment let the therapist know and they will change accordingly. We respect your boundaries and want you to feel comfortable and safe during your assessment/treatment. Personal information collected will be used and disclosed for the purpose of massage/sports injury therapy. Your personal information will not be used or disclosed for any other purpose without your prior consent.

I, \_\_\_\_\_ have read, and agree to the above statements, and give my informed and voluntary consent to the statements above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_