



MASSAGE

Confidential Patient Case History Form

Name: _____ Male Female

Address: _____ City: _____ Postal Code: _____

Email: _____ Birthdate: (Day) _____ (Month) _____ (Year) _____

Occupation: _____ Home Phone: _____ Cell Phone: _____

Medical Doctor: _____ Doctor Phone #: _____

How did you hear about us? (check one below)

<input type="checkbox"/> Google Search	<input type="checkbox"/> Facebook	<input type="checkbox"/> Instagram	<input type="checkbox"/> Twitter	<input type="checkbox"/> Yelp	<input type="checkbox"/> Referral from: _____
<input type="checkbox"/> Convention/Event	<input type="checkbox"/> Yellow Pages Online	<input type="checkbox"/> Door Hanger	<input type="checkbox"/> Flyer	<input type="checkbox"/> Get Assist	<input type="checkbox"/> Other: _____

I agree that River Stone Massage may notify me of new treatments and promotions via email. Yes No

Please indicate conditions you are experiencing or have experienced:

<p>Cardiovascular</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Chronic congestive heart failure</p> <p><input type="checkbox"/> Heart attack</p> <p><input type="checkbox"/> Phlebitis / varicose veins</p> <p><input type="checkbox"/> Stroke / CVA</p> <p><input type="checkbox"/> Pacemaker or similar device</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Dizziness / vertigo</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Blood clots</p> <p>Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Respiratory</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Chronic Cough</p> <p><input type="checkbox"/> Shortness of breath</p> <p>Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Digestive</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Crohn's Disease</p> <p><input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> Irritable Bowel Syndrome</p> <p><input type="checkbox"/> Ulcers</p>
<p>Head and Neck</p> <p><input type="checkbox"/> History of headaches</p> <p><input type="checkbox"/> History of migraines</p> <p><input type="checkbox"/> Vision problems</p> <p><input type="checkbox"/> Vision loss</p> <p><input type="checkbox"/> Ear problems</p> <p><input type="checkbox"/> Hearing loss</p>	<p>Muscle/Joint</p> <p><input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Back (<input type="checkbox"/> lower <input type="checkbox"/> mid <input type="checkbox"/> upper)</p> <p><input type="checkbox"/> Shoulders</p> <p><input type="checkbox"/> Elbow</p> <p><input type="checkbox"/> Wrist / Hand</p> <p><input type="checkbox"/> Hip</p> <p><input type="checkbox"/> Knee</p> <p><input type="checkbox"/> Ankle / Foot</p> <p><input type="checkbox"/> Spine</p>	<p>Other</p> <p><input type="checkbox"/> Loss of sensation Where? _____</p> <p><input type="checkbox"/> Diabetes Onset: _____ Type: _____</p> <p><input type="checkbox"/> Allergies / hypersensitivity What? _____</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Cancer Type/Location: _____</p> <p><input type="checkbox"/> Arthritis Type/Location: _____</p> <p><input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> Chronic fatigue</p> <p><input type="checkbox"/> Scoliosis</p> <p><input type="checkbox"/> Polio / Post Polio</p> <p><input type="checkbox"/> Osteoporosis</p>
<p>Women</p> <p><input type="checkbox"/> Pregnancy Due Date: _____</p> <p><input type="checkbox"/> Previous Pregnancy Complications: Describe: _____</p> <p><input type="checkbox"/> Menopausal problems: Describe: _____</p> <p><input type="checkbox"/> Menstrual problems: Describe: _____</p> <p><input type="checkbox"/> Gynecological conditions Describe: _____</p>	<p>Infectious Conditions</p> <p><input type="checkbox"/> Skin Conditions Describe: _____</p> <p><input type="checkbox"/> Respiratory Conditions Describe: _____</p> <p><input type="checkbox"/> Hepatitis</p> <p>Skin Conditions</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Warts</p> <p><input type="checkbox"/> Open Sores</p>	<p>Men</p> <p><input type="checkbox"/> Enlarged Prostate</p> <p><input type="checkbox"/> Libido Issues</p> <p><input type="checkbox"/> Other _____</p>

Do you have any medical conditions not listed above? Yes No

If yes, please describe: _____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of?

Yes No If yes, please describe: _____

Please circle any area causing you symptoms of pain, stiffness, numbness or other forms of discomfort:

Face	Upper Back	Arm(s)	Hand(s)	Thigh(s)	Ankle(s)	Neck
Elbow	Mid Back	Finger(s)	Knee(s)	Feet	Shoulder(s)	Wrist(s)
Hip(s)	Lower Back	Leg(s)	Toe(s)	Chest	Ribs	Tailbone

For what condition or reason are you seeking treatment today? _____

Have you seen any other health care professional(s) for this condition or reason? Yes No

If yes whom? _____

Have you ever been involved in a motor vehicle accident? Yes No Date: _____

Have you been involved in any other accidents? Yes No Date: _____

Have you ever been knocked unconscious? Yes No Date: _____

Briefly explain any surgeries you have undergone, for what and when:

Are you presently taking any prescribed medication(s)? Yes No

If yes, please record the medication(s) and the condition(s) for which it is being used if known.

Have you previously received massage therapy treatments? Yes No

If yes, were you treated: At this clinic From an RMT Other

I acknowledge that the Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge and understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. When treatment involves the use of hot stones in the massage, I take the responsibility to keep the therapist advised as to whether any of the temperatures are uncomfortable, thereby releasing my therapist and River Stone Massage of any liability. The information I have provided is true and complete to the best of my knowledge.

For insured clients:

I hereby consent to direct billing so that River Stone Massage and Wellness Centre may bill my health insurance company and have that company pay River Stone directly for my treatments. By signing this I also state that I will pay any outstanding fees for treatments received that are not covered by my insurance company.

Cancellation:

We require 24 hours' notice if you need to cancel/change your appointment so that we may accommodate another client in need of our therapeutic services. If you cancel with less than 24 hours' notice, a \$50.00 cancellation fee will be charged to your account and/or credit card. We hold encrypted credit card information on our secure server. If you forget or otherwise choose to forgo your appointment, we reserve the right to charge in full for your missed appointment.

Signature

Date

Therapist Signature