Massage Therapy College of Manitoba

Patient History

Name _____ Date _____

Address _____ Phone # (H) _____

Physician _____ (W) _____

Chiropractor, Physiotherapist, Athletic Therapist or other _____

Birthdate _____ email _____

Primary reason for appointment_____

_____

_____

Please √ conditions you are currently experiencing and circle conditions you have experienced in the past.

☐ heart conditions
☐high / low blood pressure
☐circulatory conditions
☐fainting / dizziness
☐respiratory conditions
☐nervous systems disorders
☐headaches / migraines
☐seizures
☐fractures
☐diabetes
☐osteoporosis
☐strains / sprains
☐arthritis
☐TM joint problems
☐fibromyalgia
☐skin conditions / irritation
☐whiplash
☐communicable diseases
☐infectious diseases
☐cancers
☐athletes foot
☐pregnancy
☐disorders of stomach and / or digestive tract
☐others

Have you been treated by any of the following in the last 2 years?

☐Massage Therapist ☐Physiotherapist ☐Physician

☐Specialist _____ ☐Others ☐Chiropractor

Where any of the following conducted or prescribed?

☐Physical Examination ☐X-ray ☐Ultrasound ☐H/C Therapy

☐Medication ☐Manipulation ☐Electrical ☐Other

_____

_____

Result of treatment? ☐Subsided ☐Ongoing ☐Discontinued ☐Other

_____

_____

Do you have a past history of the following?

☐Headaches / Migraines

☐Upper back pain

☐Lower back pain

☐Arm pain

☐Leg pain

☐Abdominal pain

☐Chest pain

Are you presently taking any prescribed medications?

Medication: _____
How often? _____
How long? _____

Are you presently taking any non-prescription medications? (Ex: Tylenol, Robaxacet, Vitamines, etc.)

Medication: _____
How often? _____
How long? _____

Lifestyle

Occupation _____

Recreational activities and interest _____

_____

Nutritional habits _____

_____

Sleep patterns _____

Stress level (scale 1-10) _____

Smoker ☐Yes ☐No

Massage Expectations

- Have you received a professional therapeutic massage before? _____
- Prioritize the areas of your body that you would prefer to be massaged _____
- What results do you expect from your massage sessions? _____

_____

- Therapist expectations_____

_____

The information on this form is true to the best of my knowledge.

Signature _____ Date _____