Advantage 4 Athletes 500 Denison St. Markham ON, L3R 1B9 (905) 943-4480

George W. Stonebridge RMT

416-708-9259

Case History Outline

For your information

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let us know. All the information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information. The information on this form is confidential to the clinic.

Date:_____ Client Name:_____

Client Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____ Birthday: _____

How did you hear about us:_____ Medical Dr's Name:_____

Health History: Please indicate conditions you are experience, or have experience:

Head/Neck:

☐Contact lenses ☐ Ear problems ☐ Sinus problems
☐ Glasses ☐Hearing problems ☐Headaches/Types:

Respiratory:

☐ Frequent colds ☐ Bronchitis ☐Chronic cough
☐ Emphysema ☐ Shortness of breath ☐Asthma

Are you a smoker?

☐ Yes ☐ No

Cardiovascular:

☐ Poor circulation ☐Heart attack ☐Heart disease
☐ Angina ☐Low blood pressure ☐Phlebitis
☐ High blood pressure ☐ CCHF ☐Pace maker or similar device
☐ Stoke/CVA

Muscles/Joints:

☐ Low back pain ☐ Pain all over ☐ Shoulder pain
☐ Osteoarthritis ☐Neck pain ☐ Stiffness
☐ Swelling ☐ Rheumatoid arthritis ☐ Limitation of movement

Skin:

☐ Sensitive skin ☐Do you bruise easily ☐Varicose veins
☐ Allergies to creams/oils

Digestive/Uro-gential:

☐ Poor appetite ☐ Difficult digestion ☐Kidney/bladder
☐ Pregnant (due:)

Infectious Diseases:

☐ Hepatitis ☐ Skin conditions ☐ TB
☐ HIV

Other Conditions:

☐ Diabetes (onset:) ☐ Epilepsy ☐ Cancer

HEALTH/CONSENT FORM

Name:_____ Date: _____

Emergency contact person: _____ Relationship: _____

Home Phone:_____ Cell Phone:_____

Doctors Name:_____ Phone:_____

Please note any allergies or physical conditions of which we need to be aware:

Current Medications:

Injuries:

Have you experienced any recent injuries? Nature of injuries

☐ Yes ☐ No When:

What is your general health status? ☐ Good ☐ Fair ☐ Poor

Reason for treatment: _____

Other medical conditions: (presence of internal pines, wires, artificial joints, special equipment)_____

Do you see a Chiropractor? ☐ Yes ☐ No

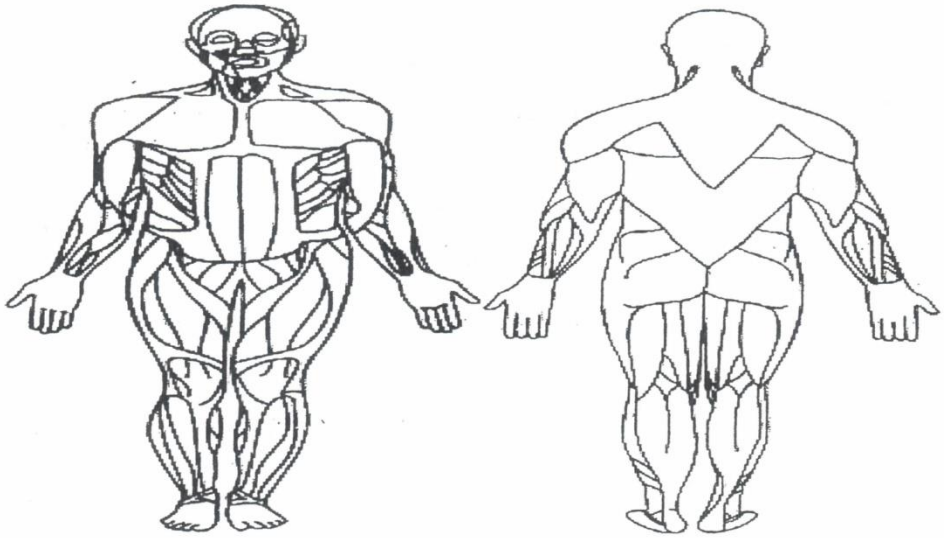
Have you experienced massage therapy before? ☐ Yes ☐ No

Signature:_____

Date:_____

For Clinical Use only:

Obtained informed consent ☐ Yes



Cancellation policy: we need 24 hours notice to cancel your appointments. Please be advised there will be a charge for missed appointments.