Fleming College

LEARN | BELONG | BECOME

Fleming College Student Massage Therapy Clinic

Confidential Patient Health Record

Date: _____

An accurate health history is important to ensure that it is safe for you to receive massage therapy.
All information is strictly confidential and will only be released with your written consent.

Please print clearly

Client Information

Name:	Address:		
City:	(Province:)	Postal Code:	
Home Phone:	Birthdate (dd/mm/yy): / /	Age:	Sex:
Occupation:	Work Phone:		
Name & Phone # of Emergency Contact:	Relationship:		
Family Physician: Address:	Phone:		

Who referred you, and contact information of referrer? _____

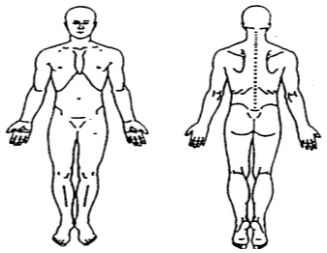
_____

General Health Status

Are you currently seeing a health practitioner? □ Yes □ No

If yes, please specify (i.e. chiropractor, physiotherapist, psychologist, etc.) and for what reason.

What is your major complaint?



Please list all current medications and/or tests (i.e. MRI, ultrasound, cat scan, etc.) and the condition:

Medication	Condition

Please list all previous injuries/surgeries and the date they occurred:

Injury/Surgery	Date

Health History

Please check any that apply to you

Muscle & Joint Pain:

Indicate L = left; R = right

- □ Neck _____
- □ Back _____
- □ Jaw _____
- □ Shoulder _____
- □ Arm _____
- □ Hand _____
- □ Hip _____
- □ Upper Leg _____
- □ Knee _____
- □ Lower Leg _____
- □ Ankle _____
- □ Foot _____

Location

- □ Fracture _____
- □ Tendonitis _____
- □ Bursitis _____
- □ Sprain _____
- □ Swelling _____
- □ Spasms _____
- □ Scoliosis _____
- □ Whiplash _____
- □ Other _____

□ **Allergies**

_____

_____

_____

_____

Respiratory

- □ Chronic cough
- □ Bronchitis
- □ Asthma
- □ Emphysema
- □ Shortness of Breath
- □ Sinus Problems
- □ Other

_____

Skin:

- □ Cold sores/herpes
- □ Rashes
- □ Warts
- □ Varicose veins
- □ Loss of sensation
- □ Athletes foot
- □ Other

_____

Reproductive

- □ Pregnant
- □ PMS
- □ Menopause
- □ Prostate
- □ Other

_____

Lifestyle Stress Level

- □ High
- □ Moderate
- □ Very Little

Cardiovascular:

- □ High blood pressure
- □ Low blood pressure
- □ Chronic congestive heart failure
- □ Blood clots
- □ Heart disease
- □ Heart attack
- □ Phlebitis
- □ Stroke
- □ Pacemaker
- □ Varicose veins
- □ _____

Digestive:

- □ Constipation
- □ Liver/gallbladder
- □ Kidney/bladder
- □ Diabetes
- □ Hernia
- □ Ulcer
- □ Colitis
- □ Other

_____

□ **Arthritis:**

Location: _____

Type: _____

Other:

- □ Anemia
- □ Artificial Joints
- □ Cancer
- □ Chronic Fatigue
- □ Depression
- □ Diabetes
- □ Eczema
- □ Epilepsy
- □ Fibromyalgia
- □ Heart Disease
- □ Hemophilia
- □ Hepatitis
- □ HIV
- □ Influenza
- □ Lumbago
- □ Measles
- □ Mental Disorder
- □ Mumps
- □ Osteoporosis
- □ Pins/Wires
- □ Pleurisy
- □ Pneumonia
- □ Polio
- □ Rheumatic Fever
- □ Small Pox
- □ Thyroid
- □ Tuberculosis
- □ Whopping Cough
- □ _____
- □ _____

Is there a family history of any of the above? Please describe:

Please read carefully:

I have stated all of my medical conditions and will inform my student massage therapist of any changes in my health status in the future.

I agree to give 24 hours notice for the cancellation of an appointment; otherwise, there will be a charge.

I understand that I may stop or alter the treatment at any time during the massage. I give my consent for the massage therapy treatment.

_____ _____

Client Name (please print) Date:

_____

Client Signature

Date of initial Health History: _____ Update 1: _____ Update 2: _____ Update 3: _____ Update 4: _____