Yarmouth Physiotherapy Inc.

2A Second St., Yarmouth, NS, B5A 1T2
Phone: (902) 881-1515 Fax: (902) 881-1313
Email: yarmouthphysio@eastlink.ca

# Massage Therapy Client Medical Information

Do you or have you ever been diagnosed with any of the following:

| | No | Yes | | No | Yes |
|---|---|---|---|---|---|
| Arthritis | □ | □ | Frequent headaches/migraines | □ | □ |
| Osteoporosis (thin / brittle bones) | □ | □ | Dizziness / fainting / nausea | □ | □ |
| Epilepsy | □ | □ | Blood disease (haemophilia, HIV) | □ | □ |
| Diabetes | □ | □ | Blood clot | □ | □ |
| High blood pressure | □ | □ | Varicoses Veins | □ | □ |
| High Cholesterol | □ | □ | Numbness/ tingling | □ | □ |
| Lung problems / Short of Breath | □ | □ | Previous or current cancer scents | □ | □ |
| Heart/Circulation Problems | □ | □ | Allergies to oils, lotions, ointments or | □ | □ |
| Stroke / TIA (mini stroke) | □ | □ | *Female: Are you or could you be pregnant? | □ | □ |

Any other major health problems:_____

**INFORMATION ABOUT YOUR PRESENT PROBLEM:**

What is your main complaint? _____

Primary Areas of Complaint:

| | | | | | |
|---|---|---|---|---|---|
| Head/ Neck | ( ) | TMJ | ( ) | Shoulder | ( ) |
| Elbow | ( ) | Wrist | ( ) | Upper Back | ( ) |
| Mid Back | ( ) | Low Back | ( ) | SI Joint | ( ) |
| Hip | ( ) | Knee | ( ) | Ankle | ( ) |

What caused your complaint? □ Injury □ Do not know □ Other

When did this problem begin? _____

Level of pain (please circle one): No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain ever

Is your pain: □ Constant □ Intermittent □ Sharp □ Dull □ Tingling □ Numbness

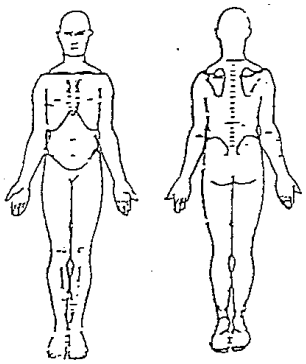
Have you ever received massage therapy before? _____

Do you experience large amounts of stress in the workplace, family or other aspect of your life?

_____

***Please complete both sides of the form (see back)***

**Mark the area(s) of pain and/or numbness on the body diagrams below:**



Have you had any motor vehicle accidents in which you were hurt?

□ No □ Yes When: _____

What other health professionals are you seeing for this problem? _____

_____

List all medications and supplements you are taking: _____

_____

**Client Consent**

Massage therapy involves the manipulation of the soft tissues of the body, skin, muscles, ligaments and connective tissues using techniques to produce therapeutic results. I fully understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. If, at any time during the treatment I am uncomfortable with my positioning, the pressure the therapist is using or the techniques that the therapist is using, I will inform the therapist so he/she can make the proper modifications to my treatment. I understand that I can stop and/or modify the treatment at any time

I have read the above information and give my informed consent for assessment and treatment by the registered massage therapist.

Yarmouth Physiotherapy Inc has a 24 hour cancellation policy. Insurance companies/WCB do not pay for missed/cancelled appointments and the client may be subject to a charge.

Signature: _____ Date: _____

---

---

**For Office Use Only:**

□ Reviewed medical information sheet with the client.

_____ _____

Date: (DDMMYYYY) Therapist's Signature