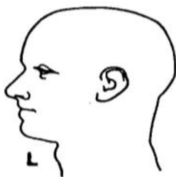
Parkwood Massage and Laser Therapy

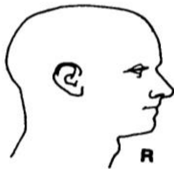
Patient Confidential Case and History Form

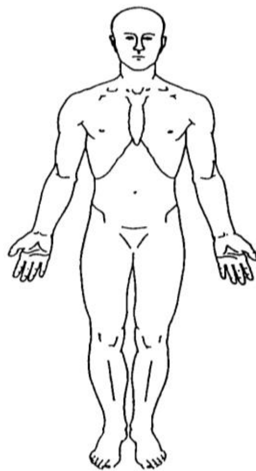
Name: ___________________________ Date: ____________________________
Address_____________________ Postal Code: _________ City: ______________
Res. Telephone#: __________________ Work Telephone #:____________________
Occupation: ________________________ Date of last physical: ________________
Pulse: ____ B.P. ____ Birth Date:__________ Weight: ______ Height: _______
Name and address of your family physician:_________________________________
Any current ongoing treatment___________________________ __________________
Referred by: ____

List in order of importance the problem(s) for which you are seeking treatment.

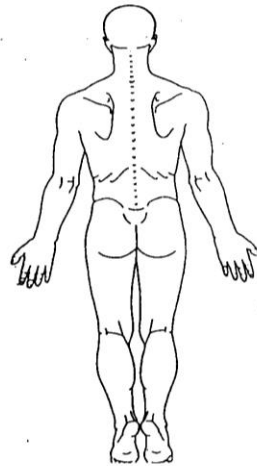
	Problem	**How long?**
1.		
2.		
3.		







PLEASE INDICATE WITH AN "X" THE AREAS OF PAIN YOU ARE EXPERIENCING



Is your condition getting progressively worse? ☐ Yes ☐ No
Is your condition interfering with your sleep? ☐ Yes ☐ No
Do you Smoke?: ☐ Yes ☐ No
Do you exercise: ☐ Regularly ☐ Occasionally ☐ Not at all
How would you describe your general health: ☐ Excellent ☐ Good ☐ Poor
Are you on any medication? ☐ Yes ☐ No
List current medications:
____
____

List any accidents, illnesses or surgeries.
____

Internal pins wires, artificial joints____

Health History: Please check the condition that you experience frequently:

Head/Neck
- ❑ Headaches
- ❑ Vision problems
- ❑ Hearing problems
- ❑ Sinus
- ❑ Frequent colds

Digestive/Uro-genital
- ❑ Constipation
- ❑ Liver/gall bladder
- ❑ Kidney/Bladder
- ❑ Difficult digestion

Other Conditions
- ❑ Diabetes
- ❑ Allergies
- ❑ anaphylaxis
- ❑ epilepsy

Respiratory
- ❑ Cough
- ❑ Shortness of breath
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema

Cardiovascular
- ❑ Low/High blood pressure
- ❑ Stroke/CVA
- ❑ Heart disease
- ❑ Congestive heart
- ❑ loss of sensation
- ❑ Hepatitis
- ❑ Infectious diseases
- ❑ Hemophilia
- ❑ cancer

Skin
- ❑ Rashes/ eruptions
- ❑ Sensitive skin
- ❑ Herpes/cold sores

Women
- ❑ Pregnant Due______
- ❑ Menopause symptoms
- ❑ Heavy/painful menstruations
- ❑ phlebitis
- ❑ TB
- ❑ HIV
- ❑ Skin conditions

Have you ever used massage therapy before? ………….

Have you been diagnosed with Osteoarthritis? …………

Have you been diagnosed with systemic/autoimmune disease? …………

Notice to Massage Therapy Clients

Canceling Appointments: There will be no charge for canceling treatments if 24 hours notice if given. **However, full charges apply to cancellations with less than 24 hours notice**. Please note: Insurance companies cannot be billed for the cost of cancelled appointments
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Arriving Late: Fees are based upon amount of time booked during designated time slots and will not be reduced upon lateness of arrival. Occasionally, if scheduling allows the therapist may be able to give treatment for the full amount of time.

Parking: Parkwood Massage Therapy is also my personal residence. I kindly ask that all patients please park on the street. There is ample legal parking.

Payment: Payment is required after treatment by either personal cheques or cash. Receipts will be issued. Special arrangements may be organized for accident insurance claims.

Agreement*: I, ____________________, agree to the above notices and, agree to be personally liable for any and all charges incurred at the Parkwood Massage Therapy clinic that are not covered by the insurance company or any third party.*

Signature: ____________________ Date: _______________