Steelcity Physiotherapy & Wellness Centre

Massage Therapy Medical Questionnaire

Name:_____ Date of Birth:_____

Primary reason for appointment: _____

Medical History *Please check off all that apply*

- ❑ Hypertension (High Blood Pressure)
- ❑ Headaches
- ❑ Allergies
- ❑ Heart condition
- ❑ Nervous Disorders
- ❑ Arthritis
- ❑ TMJ (Jaw problems)
- ❑ Whiplash
- ❑ Diabetes
- ❑ Stomach or digestive tract problems
- ❑ Respiratory problems
- ❑ Circulatory conditions
- ❑ Osteoporosis
- ❑ Skin conditions or irritations
- ❑ Cancer
- ❑ Cholesterol
- ❑ Poor circulation
- ❑ Hepatitis or HIV
- ❑ Fainting or dizziness

Do you have any past history of the following?

- ❑ Headaches
- ❑ Upper back/Neck pain
- ❑ Lower back pain
- ❑ Fractures
- ❑ Arm/Leg pain
- ❑ Pain of the abdomen/chest
- ❑ Irritation of the eyes/ears
- ❑ Surgery

Current Conditions

Please describe your present symptoms as best as you can:
(ie: Where, How When,What do your symptoms feel like...etc)

_____

_____

Have you had any of the following regarding your present condition?

- ❑ Physician's Examination
- ❑ X-ray
- ❑ Physiotherapy
- ❑ Chiropractic Treatment
- ❑ Massage Therapy
- ❑ Other

Are you currently taking any medication? (Prescription, Herbal, Non-Prescription etc,) *Please list.*

_____

_____

Does your immediate family have any of the following conditons?

- ❑ Diabetes
- ❑ Headaches
- ❑ Respiratory Disorders
- ❑ Liver Disorders
- ❑ Heart Condition
- ❑ Hypertension
- ❑ Back Pain
- ❑ Cancer
- ❑ Neurological conditions (MS, Stroke etc)

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

Signature:_____Date:_____