PRO MOTION PHYSIOTHERAPY

Massage Therapy Patient Information Sheet

Date: _____

Name: _____ Date of Birth: _____ Gender: ☐ M ☐ F
(Last) (First) (YYYY/MM/DD)

Address: _____
(Number) (Street) (City) (Province) (Postal Code)

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

E-Mail Address: _____ Best method to be contacted: ☐Cell ☐Home ☐Work ☐ E-mail
(Permission to contact by e-mail: ☐Yes ☐No)

Have you received massage therapy before? ☐ Yes ☐ No

How did you hear about Pro Motion Physiotherapy?

☐ Doctor _____
☐ Internet ☐ Our Web Page ☐ Canada 411 ☐ Yellow Pages Phonebook ☐ Phone App
☐ Registered Massage Therapy Association of Ontario (Find an RMT near you)
☐ College of Massage Therapists (Find an RMT)
☐ Promenade Mall Advertising
☐ Someone who has been here before _____ May we send them a thank you note? ☐ Yes ☐ No
(Name)
☐ I had treatment at Pro Motion Physiotherapy in the past
☐ Other _____

Please circle the main reason you chose Pro Motion Physiotherapy

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Would you like to receive information about upcoming lectures, special events, clinic news, and health and wellness?
☐ Yes ☐ No

The information requested will assist in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

To see our Privacy Policy, please go to www.promotionphysiotherapy.com

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Massage Therapy Health Questionnaire

Patient Name: _____ Date: _____

Please indicate conditions you are experiencing or have experience

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis/varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease

Is there a family history of any of the above?
☐ Yes ☐ No

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

Is there a family history of any of the above?
☐ Yes ☐ No

Infections
- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Other Conditions
- ☐ loss of sensation, where? _____
- ☐ diabetes, onset: _____
- ☐ allergies/hypersensitivity to type of reaction: _____
- ☐ epilepsy
- ☐ cancer, where? _____
- ☐ skin conditions, what? _____
- ☐ arthritis

Is there a family history of arthritis?
☐ Yes ☐ No

Head/Neck
- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Women
- ☐ pregnant, due: _____
- ☐ gynecological conditions, what? _____

Overall, how is your general health?
_____

Primary Care Physician:
Name:
_____
Address:
_____
Phone:
_____

Emergency Contact: Name:_____ Phone number: _____ Relationship: _____

Current medication(s):
_____

Condition treated:
_____

Are you currently receiving treatment from another health care profession? ☐ Yes ☐ No
If yes, for what? _____

Surgery - date _____
nature: _____

Injury - date _____
nature:_____
_____
_____

Notes:

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness)
☐ Yes ☐ No
what? _____

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No
what? _____
where? _____

What is the reason you are seeking massage therapy? Please indicate the location of any tissue or joint discomfort.
_____
_____
_____

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