SANDRA VIAES
REGISTERED MASSAGE THERAPY

PATIENT CASE HISTORY FORM

Name: ______________________________ **Date of Birth:** month / day / year ____________

Address: ____

City: ____________________ **Postal Code:** ____________

Phone: (home) ____________________ **Family Doctor:** ____________________

(work) ____________________ **Dr. Address:** ____________________

(cell) ____________________ **Dr. Phone #:** ____________________

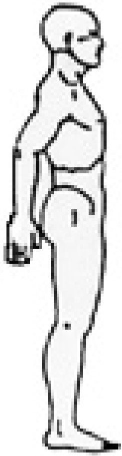
Email : ____________________ **Occupation:** ____________________

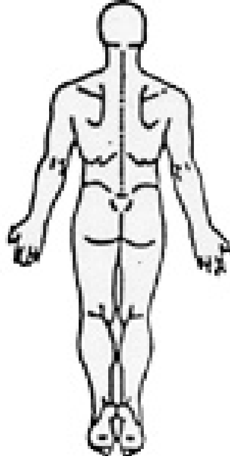
Do you have any sensitivities or allergies to oils, creams, scents?: **YES** **NO**

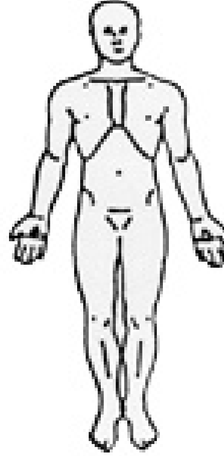
If so, which ones: ____

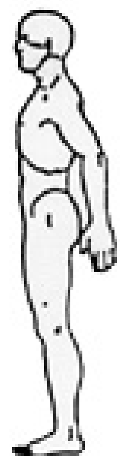
MAJOR COMPLAINTS: ____

Circle the areas on your body where you are experiencing aches, pains, numbness or discomfort









Have you experienced this condition / injury in the past? **YES** **NO**

Have you seen a Massage Therapist before? **YES** **NO** For this condition / injury? **YES** **NO**

What makes the condition worse?: ____

What makes the condition better?: ____

For Office Use ONLY	Updated: ____________	Updated: ____________
	Updated: ____________	Updated: ____________
	Updated: ____________	Updated: ____________

Circle ALL that apply

Cardiovascular System	Nervous System	Digestive System	Respiratory System
Aneurysm High blood pressure Low blood pressure Heart disease Stroke Varicose veins Phlebitis Bruise easily Pacemaker	Multiple sclerosis Parkinson's Seizures /epilepsy Carpal tunnel Altered/ loss sensation Specify Areas: __________ __________ __________	Ulcers Constipation Crohn's disease Gall stones Irritable bowel syndrome(IBS) Liver disease Other :	Bronchitis Asthma Emphysema Sinusitis Chronic cough Breathing problems Sleep Apnea Other :
Skin	**Head and Neck**	**Muscles and Joints**	**Other Conditions**
Plantar warts Eczema Psoriasis Fungal infection Herpes simplex Other:	Headaches Migraines Vision problems Hearing/Ear problems Dizziness	Fibromyalgia Osteoporosis Arthritis Pain & stiffness Head Neck Jaw Back (low – mid- upper) Arm/ hand (right – left) Shoulder (right – left) Leg / foot (right – left)	Hepatitis HIV / AIDS Diabetes Chronic fatigue syndrome Allergies Specify: __________ Tumors / cysts Cancer Specify: __________
Medications	**Other Health Care**	**Surgeries / Pins /Plates**	**WOMEN**
Please indicate the type and what it is for: __________ __________ __________ __________	Physician/ Medical doctor Chiropractor Massage therapist Naturopath Homeopath Nutritionist /Dietician	Please indicate type and date: __________ __________ __________ __________	Menopausal problems Painful menstruation Caesarean Section Endometriosis **Pregnant:** Weeks Due Date

CONSENT

Your appointment time has been reserved for you! In courtesy of your therapist and other clients, please arrive on time for your treatment. If you are late for your appointment the therapist will not extend your time if there is another appointment immediately after yours. We ask that you provide us with 24 hours advance notice to cancel or re-schedule. You are responsible for the full cost of your booked treatment if missed or cancelled without sufficient notice.

I have read and understand the following statements:
I authorize Sandra Viaes RMT to collect my personal and medical information as documented above in order to contact me regarding my appointments. I also understand that my personal and medical information is confidential and will only be disclosed to the treating therapist.

I agree that the use of alcohol and non-medicinal drugs diminishes the ability of the therapist to achieve desired results and will result in immediate termination of the session. I also understand that any illicit or sexually suggestive remarks or advances made by myself will result in immediate termination of the session while payment for the appointment will be made in full.

I understand that I may experience soreness, bruising, headaches or dizziness post treatment and that I should inform my therapist of any side effects immediately so that they can make note of it and adjust further treatment accordingly.

Print Name:____________________ Signature:____________________
(If Patient is under 16 years of age, a guardian must sign the form)