CONFIDENTIAL PATIENT HISTORY

I am so looking forward to working with you!
Please fill out this form to bring to your treatment.

Cori Watson, RMT

PATIENT INFORMATION

Name:

Address:

City:

Home Phone: Cell Phone: Work Phone:

Email:

Date of Birth (D/M/Y): Current Age:

Gender: M F Height: Weight:

Number of Children: Ages:

Occupation:

Employer:

HEALTHCARE INFORMATION

Referred By:

Family Physician: Location:

Have you been seen/are you currently seeing any of the following?

Specialist Name:

Chiropractor Name:

Massage Therapist Name:

Physiotherapist Name:

Other Therapy Name:

MEDICAL INFORMATION

Are you presently under medical treatment or have other health concerns?

What is the PRIMARY complaint that brings you in for treatment today?

Any secondary complaints you would like to address?

Describe pain, range of motion limitations, or challenges caused by symptoms:

How and when did these issues begin?

Please list history of trauma (physical or emotional), accidents, or surgery:

What are your goals for therapy?

MEDICAL HISTORY

Please check any of the conditions you've had in the past, or currently have:

- Cardiovascular Disease
- Neurological Condition
- Sinus Problems
- Arthritis (Osteo / Rheum)
- Depression
- Anxiety
- Asthma / Difficulty Breathing
- High Blood Pressure
- Constipation / Diarrhea
- Vertigo / Dizziness
- Varicose Veins
- Digestive Problems
- Thyroid Condition
- Diabetes (Type 1)
- Diabetes (Type 2)
- Pregnancy
- Osteoporosis
- Multiple Sclerosis
- Numbness / Tingling
- HIV / AIDS
- Fibromyalgia
- Tendonitis
- Chronic Infections
- Epilepsy / Seizures
- Sprains/ Strains
- Kidney Disease
- Chronic Fatigue Syndrome
- Muscle / Joint Pain
- Congestive Heart Failure
- Headaches/ Migraines
- Blood Clots
- Tension / Stress
- Back or Neck Pain
- Rash / Skin Conditions
- Sleep Disorders
- Chest Pain / Tightness
- Eyestrain / Irritation
- TMJ / Jaw Pain
- Earaches / Ringing in Ears
- Menstrual Issues

INFORMED CONSENT TO THERAPY

Cori Watson, Registered Massage Therapist Informed Consent to Massage Therapy

I understand that the massage therapist is providing massage therapy services within her scope of practice as defined by the Massage Therapist Association of Saskatchewan Inc.

I hereby consent to my therapist to treat me with massage therapy for the above noted purposes including assessments, examinations, and techniques, which may be recommended by my Therapist.

I acknowledge that the Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I knowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Therapist must be fully aware of my existing medical conditions. I have completed my medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the Therapist all of the medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I have read the above noted consent and I have had the opportunity to question the consent and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my Therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that any time I may withdraw my consent and treatment will be stopped.

Patient Name: **Signature:**

Witness: **Signature:**

Date: