ray clinic
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# Registered Massage Therapy Medical History Form

Please take a few moments to complete this medical form. An accurate health history is important to ensure that it is safe for you to receive massage. All information gathered for this treatment is confidential, except as required by law. Thank you for choosing Ray Clinic.

Do you currently have an open ICBC claim? ☐ Yes ☐ No Do you currently have an open WCB claim? ☐ Yes ☐ No
If you currently have an open WCB claim, we are unable to treat you at this time.

Name: _____ (If you are already a patient of Ray Clinic, please proceed to the next section)

Address: _____ City: _____ Postal Code: _____

E-mail: _____ E-Mail Newsletter Consent: Yes_____ No ____ Gender: Male Female

Home Phone#: _____ Work/Cell Phone#: _____ Occupation: _____

Date of Birth: _____ _____ _____ Physician's Name: _____ Physician's Phone#:_____
Month Day Year

How did you hear about Ray Clinic / RMT? _____

Please check the boxes pertaining to areas of concern you are currently experiencing, or have experienced in the past, and indicate if it affects/affected your left (L) or right (R) side where applicable:

## Soft Tissue/Joints/Bones

☐ Neck L R
☐ Upper back L R
☐ Mid back L R
☐ Low back L R
☐ Shoulder L R
☐ Arms L R
☐ Elbow L R
☐ Wrist L R
☐ Hands L R
☐ Hip L R
☐ Legs L R
☐ Knees L R
☐ Ankle L R
☐ Foot L R
☐ Osteoarthritis/Rheumatoid Arthritis
☐ Artificial implants/rods/plates
☐ Disc problems
☐ Osteoporosis/ Osteopenia
☐Fractures/ Dislocation

## Head and Neck

☐ Headaches Type: _____
☐ Head Injury Date: _____
☐ Blurred Vision ☐ Corrective Lenses
☐ Dizziness ☐Fainting
☐ Tooth/Jaw Pain
☐ Ear Pain
☐ Hearing Impairment

## Digestive/Urogenital

☐ Ulcers
☐ Nausea
☐Painful or difficult urination
☐ Diarrhea/Constipation
☐ Abdominal/ Inguinal Herniation
☐ Irritable Bowel/Colitis/ Crohn's
☐ Liver condition _____
☐ Digestive disorder

## Cardiovascular

☐ Heart Attack
☐ High/Low Blood Pressure
☐ Stroke/Aneurysm
☐ Pacemaker
☐ Heart Disease/Condition
☐ Phlebitis
☐ Anemia
☐ Bruise easily
☐ Varicose Veins
☐ Hemophilia
☐ Blood clots
☐ Other:_____

## Respiratory

☐ Asthma
☐ Bronchitis
☐ Shortness of breath
☐ Tuberculosis
☐ Pneumonia
☐ Emphysema
☐ Chest pain

## Skin Conditions

☐ Skin Condition Specify: _____
☐ Impaired sensation
☐ Fungal Infections
☐ Acne
☐ Undiagnosed Mole/s

## Other Conditions

☐ Neurological Condition _____
☐ Diabetes Type: _____
☐ Cancer Type: _____
☐ Arthritis Type: _____
☐ Epilepsy/ Seizures
☐ Fatigue/ Low energy
☐ Insomnia
☐ Hyper/ Hypo Thyroid
☐ Multiple Sclerosis
☐ SLE
☐ Undiagnosed Tumor/Lump
☐ Depression/Anxiety

## For Women

☐ Menstrual difficulties
☐ Pregnant Approx. Due Date: ___/__ /___
☐ Menopausal concerns m d y
☐ Breast tissue discomfort/pain
☐ Endometriosis
☐ Birth Control Type: _____
☐ Disease of the breast/uterus/ovaries
Details: _____

## Infectious Disease

☐ Hepatitis
☐ HIV/AIDS
☐ Herpes
☐ Other: _____

RMT Notes:

Please list any medications and/or non-prescription vitamins or supplements you are presently taking and the reason for taking them:

| Medication | Non-Prescription | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Known allergies (including medications, foods, oils, lotions, seasonal, latex etc.):

_____

Past surgeries, illnesses, accidents and any relevant medical history:

_____

Please indicate the following healthcare practitioners from which you currently receive regular treatment:

☐ Massage Therapist ☐ Chiropractor ☐ Naturopathic Doctor ☐ Physiotherapist ☐ Medical Doctor ☐ Other _____

What are your goals for seeking massage therapy treatment? _____

Circle the number you are currently experiencing in each category; 1 being the lowest level and 10 being the highest level:

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Stress Level: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Energy Level: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Pain Present: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Activity Level: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Current Condition:

Describe your current condition and symptoms: _____

How long have you experienced this? _____

How did it start? _____

What relieves the symptoms? _____

What aggravates the symptoms? _____

Please Note:

I, the undersigned, have answered the above questions to the best of my ability and the information provided is current. I understand that a Registered Massage Therapist (RMT) will work with me using this information, and other assessment skills, to prepare a safe and effective treatment session, and I give consent to this treatment. I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its' associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I understand that I am responsible for the full payment of each massage treatment I receive. I will give 24 hours' notice to cancel an appointment, or I may be held responsible for the payment of the missed appointment.

_____ _____ _____

Patient/Guardian's Signature if a minor < 18 years old | Date (m/d/y) | RMT Initials