CEDAR HILL
Sports Therapy Clinic

Massage Therapy: Confid ential Medical Health History

Name:_____

Major complaint:_____

What makes your current condition **worse**?_____ **Better**?_____

Have you had this condition in the past? Yes ◯ No ◯ If yes, was it resolved? Yes ◯ No ◯

What **medications** are you currently taking, and why?_____

Please list any **surgeries**, **major injuries**, or **accidents** you have had:_____

What is your current **level of stress**? None / Slight / Moderate / Severe

What is your current level of **physical activity**? None / Low / Moderate / High

What recreational activities do you engage in?_____

Are you **currently** being seen by: Chiropractor / Physiotherapist / Acupuncture & TCM / Naturopath / Other

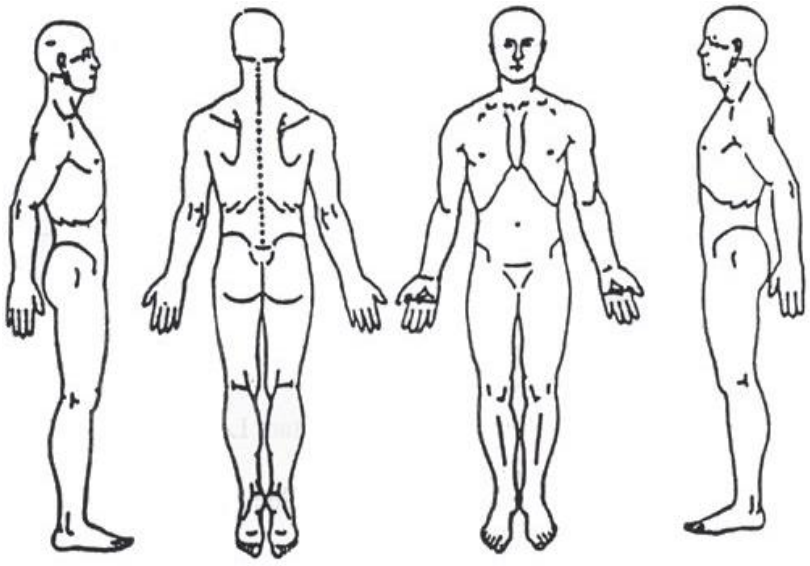
Please **circle any** of the following **that apply to you**:

Heart Condition	Osteo/Rheumatoid Arthritis
Stroke (CVA)	Fibromyalgia
High/Low Blood Pressure	Spinal Injury
Respiratory Conditions	Loss of Sensation/Tingling
Pregnancy	Diabetes
Fractures/Dislocations	Varicose Veins
Menstrual Problems	Dizziness
Skin Conditions	Digestive Disorders
Headaches (recurrent)	Seizures
Cancer/Tumours/Cysts	Contagious Condition

Allergies:_____

Other:_____

Please **mark** on the diagram any **areas of concern**:



Is this an **ICBC claim**? Yes ◯ No ◯ Date of accident (MM/DD/YYYY): __ __/__ __/__ __ __ __

To the best of my knowledge the above is a true statement of my physical condition.

Signature:_____ Date(MM/DD/YYYY): __ __/__ __/__ __ __ __