Liba Cunnings
Registered Massage Therapist

Medical History Form

Please print your information clearly

DEMOGRAPHIC INFORMATION

Name

Surname | Middle Initial | First

Address

Street no. | Postal Code

Telephone

Home | Work | Cell

E-mail

Age | Birth Date (dd-mon-yy) | Occupation

MEDICAL HISTORY

SOFT TISSUE INJURIES

Whiplash		Joint replacement	
Spinal injuries		Joint surgeries	
Disc problems		Sprains	
Fractures		Dislocation	
Tendonitis		Foot problems	
Muscle tears		Other	

CARDIO-VASCULAR SYSTEM

Varicose veins		High blood pressure	
Stroke, TIA		Heart conditions	
Blood clots		Other	

DIGESTIVE SYSTEM

Constipation		Diarrhea	
Bloating		Acid reflux	
Allergies		Other	
Skin rashes			

HEAD

Headaches		Head injuries	
Migraines		Concussions	
Earaches		Tooth aches	
Tinnitus		Dental surgeries	
Balance problems		Other	
Extensive dental work			

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MEDICAL HISTORY

NEUROLOGICAL

Muscle weakness		Multiple Sclerosis	
Numbness		Parkinson's	
Abnormal sensations		Muscular Dystrophy	
Meningitis		Other	

GENERAL HEALTH

Asthma		Diabetes	
Cancer		Other	
Surgeries			

FEMALES ONLY

Are you pregnant?		If 'yes", what month	
Menstrual Cycle:			
Normal		Back Pain	
Irregular		Headaches	
Too light		Water Retention	
Too heavy			
Number of children		Other complications	
Delivery:			
Vaginal			
Caesarian			
Number of pregnancies			

LIFESTYLE

Activities, recreational/competitive sports

Are you currently under the care of a physician, naturopath, chiropractor, or physiotherapist?

MAIN REASON FOR VISIT

I hereby certify that the above given information is complete and true to the best of my knowledge and belief.

Signature _____ Date: _____

ACCOUNTS ARE PATIENT'S RESPONSIBILITY REGARDLESS OF INSURANCE COVERAGE