Ridge Star Wellness
Confidential Medical History

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone #: _____ (h) _____ (c) _____ (w)

Occupation: _____ How long? _____

Male / Female / prefer not to say Height: _____ Weight: _____

Date of Birth: (MM/DD/YY) _____ Age: _____

Email Address: _____

Your email address is strictly for the use of Ridge Star Wellness and will not be shared or sold.

Would you like to receive our newsletter? Yes / No

You can unsubscribe at any time.

How did you hear about Ridge Star Wellness? _____

Family Doctor: _____ Date of last visit: _____

Reason for visit: _____

Comments: _____

Have you been for any of the following treatments in the last 12 months? ***Please check all that apply.***

- ☐ Massage Therapy Reason for visit: _____
- ☐ Physiotherapy Reason for visit: _____
- ☐ Reflexology Reason for visit: _____
- ☐ Acupuncture Reason for visit: _____
- ☐ Conditioning Therapy Reason for visit: _____

In Case of Emergency

Contact Name: _____

Relationship: _____ Ph #: _____

Do you do stretches? Yes / No How Often? _____

Do you exercise? Yes / No How Often? _____

What kind? _____

Do you use: ☐ Heat pads / ice packs ☐ Heating / cooling salves or creams ☐ TENS machine

How many hours a night do you sleep? _____

Is your sleep restful? Yes / No

If no, explain: _____

_____

Please circle all that apply

Water	glasses per day	None	1 - 3	3 - 5	5 - 10	More
Coffee	cups per day	None	1 - 3	3 - 5	5 - 10	More
Alcohol	drinks per day	None	1 - 3	3 - 5	5 - 10	More
Smoking	packs per day	None	<1/2 pack	full pack		More

Have you had any **serious falls, accidents or injuries** in the past 5 years? Yes / No

Explain: _____

Date(s) of occurrence: _____

Have you had any **surgeries** in the past 5 years? Yes / No

Explain: _____

Date(s) of occurrence: _____

Have you been in any **motor vehicle accidents** in the past 5 years? Yes / No

Explain: _____

Date(s) of occurrence: _____

Current Medications

It is sufficient to state the purpose (cholesterol, high blood pressure, osteoporosis, anxiety, pain, blood thinners, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Therapist Notes: _____

_____

_____

Please check all that apply, now and <u>in the past 3 years.</u>

- ☐ Arthritis Osteo / Rheumatoid
  - Location: _____
- ☐ Blood clots
  - Location: _____
- ☐ Blood pressure high / low
- ☐ Bruise easily
- ☐ Bulging / Herniated disc
  - Location: _____
- ☐ Cancer
  - Location: _____
  - When: _____
- ☐ Chest pain Now / In the past
- ☐ Diabetes Type I / Type II
  - Controlled by: diet / pills / injection / pump
- ☐ Dizziness
  - Cause: _____
- ☐ Edema (swelling)
  - Location: _____
- ☐ Fatigue, chronic
- ☐ Fibromyalgia / Polymyalgia
- ☐ Headaches and/or Migraines
  - Frequency: _____
  - Length: _____
  - Controlled by: _____
- ☐ Heart problems
  - Heart attack
    - Date: _____
  - Other (specify): _____
    - Date: _____
- ☐ Hernia
  - Location: _____
- ☐ Infection
  - Type: _____
- ☐ Joint replacement
  - Location: Hip L / R Shoulder L / R
  - Knee L / R Other: _____
- ☐ Mental Health
  - ☐ Stress
  - ☐ Anxiety
  - ☐ Depression
- ☐ Osteoporosis
- ☐ Pregnancy Yes / No
  - If yes, how far along? _____
  - Any risk factors? _____
- ☐ Scoliosis
- ☐ Seizures
  - Type: _____
  - Frequency: _____
- ☐ Skin conditions
  - ☐ Psoriasis Location: _____
  - ☐ Rosacea Location: _____
  - ☐ Other Specify: _____
    - Location: _____
- ☐ Sleep / Energy problems
- ☐ Stroke
  - Date: _____
- ☐ Thyroid problems Hypo / Hyper

Therapist Notes: _____

_____

_____

Do you have any conditions / pain **NOT** on this list? Yes / No

If yes, please explain _____

_____

_____

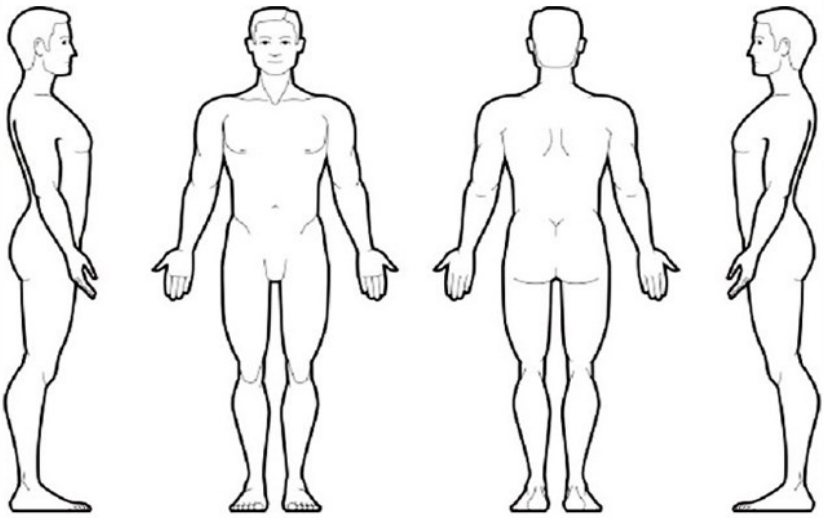
_____

_____

Please check all that currently apply.

- ☐ Ankle problems L / R
- ☐ Carpal Tunnel Syndrome L / R
- ☐ Elbow pain
  - Tennis / Golf L / R
- ☐ Hamstring pain / tightness L / R
- ☐ Hip pain L / R
- ☐ Jaw / TMJ problems L / R
- ☐ Knee pain L / R
- ☐ Pelvic pain
- ☐ Plantar fasciitis / Morton's Neuroma L / R
- ☐ Rib pain
  - Location: _____
- ☐ Sciatica L / R
- ☐ Shin splints L / R
- ☐ Shoulder problems L / R
- ☐ Wrist / Thumb pain L / R

Shade in the site(s) of discomfort/pain on the anatomical drawing and rate the severity on a scale from 1 - 10.



Right Front Back Left

Pain Intensity Scale

(2) **Mild Pain** *(annoying, nagging)*

(4) **Discomforting** *(troublesome, numbing)*

(6) **Distressing** *(miserable, agonizing, gnawing)*

(8) **Intense** *(Cramping, dreadful, horrible)*

(10) **Excruciating** *(tearing, crushing, unbearable)*

Numbness: Mark area with an **X**

List in order of importance to you.

1. **Complaint**: _____ Severity 1 - 10 *(10 most severe)*: _____

Initial Onset: _____ Probable cause: _____

What makes your pain worse? _____

Activities compromised: _____

2. **Complaint**: _____ Severity 1 - 10 *(10 most severe)*: _____

Initial Onset: _____ Probable cause: _____

What makes your pain worse? _____

Activities compromised: _____

3. **Complaint**: _____ Severity 1 - 10 *(10 most severe)*: _____

Initial Onset: _____ Probable cause: _____

What makes your pain worse? _____

Activities compromised: _____

I have stated, to the best of my knowledge, my known medical conditions and will inform my therapist of any changes. I understand that the massage therapist does not diagnose illness or disease.

Signature: _____ Date: _____

Massage Information

What type of massage are you seeking? ☐ Relaxation / Self-care

☐ Therapeutic / Palliative / Health Care

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Are there any areas you do not want worked on? (eg. face, abdomen, hands, feet, etc.) Yes / No

Please specify: _____

What are your goals for this treatment session? _____

Is there anything else you would like your therapist to know? Yes / No

Please advise: _____

_____

_____

For Massage Therapist Use

Additional Information from Intake / Interview

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____