Core Solutions Physiotherapy & Wellness
Massage Medical History Form

Name:_____**Date:**_____**Age:**_____
Last First

Address_____
Street City Province Postal Code

Home Telephone:_____**Business Telephone:**_____

Email:_____

Occupation:_____

Birth Date:_____Male:_____Female:_____

General Practitioner:_____Telephone:_____

Date of Last Medical Examination:_____

List Any Past Surgery: Past Injuries/Accidents

_____ _____

_____ _____

_____ _____

Please list all medications you have taken in the last 6 months (med and reason)

_____

Are you currently undergoing any forms of treatment? Please detail

_____

Do you exercise regularly (i.e. 3 times per week) Yes/No_____

Please check if you have any of the following symptoms during, or shortly after exercise:

Muscle Soreness		Headaches		Chest Pain		Abdominal Pain	
Weakness		Fatigue		Dizziness		Other	

Please check ANY past and current health problems			
Hemophilia		Cancer	
Anemia		Undiagnosed Lump	
Heart Attack		Gout	
Aneurysms		Ankylosing Spondylitis	
Severe High Blood Pressure		Osteoarthritis	
Hardening of the Arteries		Rheumatid Arthritis	
Chronic or Long Lasting Thrombosis		Lupus	
Phlebitis (swollen veins)		Reiter's Syndrome	
Buerger's Disease		Joint Instability	
Severe Varicose Veins		Scleroderma	
Neuritis (swollen Nerve)		Polymyalgia	
Epilepsy		Local irritable skin condition	
Emphysema		Contagious/infection	
Asthma		Acute inflammatory condition	
Diabetes		Hernia	
Multiple Sclerosis		Chronic abdominal disease	
Chronic Kidney Disease		Prolonged constipation	
Immunological Disease		Endometriosis	
HIV		Pelvic Inflammatory disease	
Tuberculosis		Alcohol or drug addiction	
Stroke		Hepatitis	
Flaccid Paralysis		Osteoporosis	
Please check if you have EVER experienced any of the following:			
Bruise easily		Hearing loss in one/both ears	
Fainting		Difficulty swallowing	
Breathing Difficulty		Numbness or loss of sensation	
High Blood Pressure		Loss of consciousness	
Swollen joints		Diminished vision	
Dizziness		Slurred Speech	
Chest Pain		Confusion	
Rapid Heart beat		Weakness or loss of strength	
Poor Circulation		Sudden collapse	
		Low blood pressure	

Client signature _____