

CONFIDENTIAL CASE HISTORY

REFERRED BY _____

NAME _____ CELL PHONE: _____

ADDRESS _____ HOME/WORK PHONE: _____

CITY, STATE, ZIP _____ EMAIL _____

AGE _____ DATE OF BIRTH _____ OCCUPATION _____

EMERGENCY CONTACT: Name / relationship: _____ Phone: _____

1. PRESENT SYMPTOMS: MAJOR COMPLAINT: _____

2. MINOR COMPLAINTS (Other areas of pain or concern): _____

3. When did you first notice major issue? _____

4. What brought it on? _____

5. What activities aggravate condition? _____

6. Is this condition getting worse? Yes ___ No ___ Constant _____ Comes and goes _____

7. Does this interfere with your Work? _____ Sleep? _____ Daily Routine? _____

8. What do you believe is wrong with you? _____

9. What provides relief? _____

10. Medical diagnosis? ___ If so, what was it? _____

By whom? (type of health professional) _____

PAST HISTORY:

Have you had similar problem(s) before? ___ If so, when? _____ What brought these on? _____

What relieved them? _____

Did they disable you? _____ Prevent you from working? _____ Hospitalize you? _____

What was previous diagnosis? _____ What treatments? _____

Did they help? _____

HABITS:	Heavy	Moderate	Light	None
Alcohol	___	___	___	___
Coffee	___	___	___	___
Tea	___	___	___	___
Tobacco	___	___	___	___
Exercise	___	___	___	___
Weekly Sugar Consumption	___	___	___	___

MEDICATIONS: Type: _____ For What: _____

Have you ever Had any operations? Yes ___ No ___ Describe briefly _____

Broken any bones? ___ ___ _____

Been in accident? ___ ___ _____

If yes, did you have whiplash? _____

DO YOU HAVE DIFFICULTY WITH ANY OF THE FOLLOWING?

HEAD:

- Headaches
- Shooting head pain
- Light bothers eyes
- Sinus trouble
- Loss of smell
- Hayfever
- Asthma
- Allergies, specify _____

- Loss of taste
- Tightness in throat
- Inflammation of throat
- Thyroid Issues
- Face flushed
- Twitching of face
- Jaw pain (TMJ disorder)
- Ringing in ears

NECK & ARMS:

- Muscle spasms in neck
- Grating in neck
- Whiplash or neck trauma
- Tightness in shoulders
- Pain in arms & shoulders
- Pins & needles in arms & hands
- Pain between shoulder blades
- Carpal tunnel syndrome
- Painful or swollen joints
- Limited movement in joints

SKIN:

- Allergies, specify _____

- Rashes
- Cosmetic Surgery
- Herpes/Cold sores
- Athletes Foot

BACK & LEGS:

- Sciatica
- Pinched nerves in back
- Slipped or herniated disc
- Pins & needles in legs
- Leg or foot pain
- Scoliosis
- Pain in hips/low back
- Cold feet
- Swelling of feet or ankles
- Limited movement in joints

DIGESTIVE:

- Nervous stomach
- Irritable Bowel Syndrome
- Crohn's Disease
- Colitis
- Ulcers
- Diabetes
- Inner tension
- Liver/Gall bladder issues
- Kidney/bladder trouble
- Indigestion
- Intestinal gas
- Constipation

REPRODUCTIVE:

- Pregnant, Stage _____
- Ovarian problems
- Pre-menstrual tension
- Painful menstruation or cramps
- Menopausal symptoms, specify – _____

- Prostate trouble

CIRCULATORY:

- Cold sweats
- Cold hands
- Chest pains
- Shortness of breath
- Tuberculosis
- Heart pain
- Heart palpitations
- Heart attacks
- High/low blood pressure
- Anemia
- Phlebitis/Varicose veins
- Lymphedema

NERVOUS SYSTEM:

- Loss of memory
- Fatigue
- Depression
- Head feels too heavy
- Dizziness
- Fainting
- Loss of balance
- Seizures
- Shingles

GENERAL:

- Anxiety/Stress
- Depression
- Arthritis
- Osteoporosis
- Cancer: Type _____
- Emphysema
- Sleeping problems
- Contact lenses
- Dentures
- Hearing aids

ANY OTHER MEDICAL CONDITION(s) not listed: _____

Please explain any of the above conditions: _____

MESSAGE EXPERIENCE:

Have you had professional massage before _____ If yes, what types of massage have you had? (Swedish, deep tissue, shiatsu, etc.) _____

How long have you been receiving massage? _____ Frequency? _____

What are your goals for treatment? _____

CONTRACT FOR CARE:

I will participate fully as a member of my healthcare team.. I will make sound choices regarding my session's plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his/her skills and knowledge. I will freely ask questions of my practitioner as needed or desired.

Signature: _____ Date _____