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 Yes No Describe briefly

Had any operations? __ __ _____

_____

_____

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:_____

_____

MASSAGE 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 πwill freely ask questions of my practitioner as needed or desired.

Signature:_____Date_____