CONFIDENTIAL CASE HISTORY .... Date: ______________________________

Name ____ Email: ______________________________

Phones: Day______________________ Evening_____________________ Cell_________________

Address__________________________________ City_________________ State_____ Zip _________

Age _______ Date of birth_____/_____/_____ M___F___ Marital status_____ #of children ________

Occupation ___________________________________How did you hear about us ?________________

Who is responsible for payment ? ___________________ (If insurance, please complete ins. forms)

Have you had massage therapy before ?__________Where and by whom ?________________________

What is your major area of pain or concern?____

____

____

When did you first notice it ? ___________________________What brought it on ?__________________________

What activities aggravate it ?____

Is this condition getting worse ? Yes_____No____ Does it interfere with work ______ sleep _____recreation ______

What do you believe is wrong with you ?____

What have you done to get relief ? ____

Has there been a medical diagnosis ?____Exam? ____ Blood work ? ____ X-rays ? ____ Other: __________________

What was the diagnosis ? ___________________________________By whom ?____________________________

Other areas of pain or concern:____

____

____

PAST HISTORY

Have you ever had a similar problem before ? ____When ? _________What caused those episodes?________________

_______________________________________What relieved them ? ____

What was the previous diagnosis ? ________________________What treatments ? ________________________

Did they help ? _____Have you had massage therapy for these conditions ?_____If so, did it help?_______________

Are you presently under a doctor's care ? ____ If so, for what condition?________________________________

Name of physician _________________________________City _________________State___ Phone_____________

Are you taking any: ( ) medications List them ____

( ) Laxatives ( ) Sedatives ( ) Sleeping pills ( ) Insulin ( ) Blood Thinners ( ) Pain pills (type:_____________)

( ) Vitamins ( ) Herbs ( ) Minerals ( ) Birth control pills ( ) Homone Replacement ( ) Other______________

Indicate the following habits with: H-heavy M- moderate L-light N-none

_____Alcohol _____Coffee _____Tea ____Tobacco ____ Colas ____ Sugared products ____ Artificial Sweetners

_____White flour products _____ Exercise

Cravings:____

Previous operations____

Previous broken bones ____

Previous accidents or injuries ____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM.

Circle any CURRENT conditions. Underline any you have had as PAST problems.

Headaches
Shooting pains in head
Sinus trouble
Loss of smell
Loss of taste
Tightness in throat
Inflammation of throat
Thyroid trouble
Face flushed
Twitching of face
Loss of memory
Fatigue
Depression
Head feels too heavy
Dizziness
Fainting
Loss of balance
Ringing in ears
Wear glasses
Light bothers eyes
Hayfever
Asthma
Epilepsy or other seizures
Excessive perspiration

Muscles spasms in neck
Grating in neck
Tightness in shoulder muscles
Neuritis in shoulders & arms
Pins & needles in arms & hands
Cold hands
Chest pains
Shortness of breath
T. B.
Heart pain
Heart palpitations
Heart attack
High blood pressure
Low blood pressure
Anemia
Blood clots, phlebitis
Anemia
Rheumatic fever
Nervous stomach
Stomach trouble
Ulcers
Nervousness
Inner tension
Skin disorders

Cold sweats
Liver trouble
Gallbladder trouble
Indigestion
Intestinal gas
Constipation
Kidney trouble
Bladder trouble
Diabetes
Cancer
Sleeping problems
Painful joints
Swollen joints
Arthritis
Herniated or bulging disk
Pinched nerves in back
Pins & needles in legs
Swollen ankles
Cold feet
Pains in legs & feet
Sciatica
Numb hands or feet
Varicose veins
Other: ________________

Male only:
Burning during urination
History of prostate trouble
Urination difficult or dribbling
Frequent night urination
Pain in the groin area
Diminished sex drive
Burning or pain during orgasm

Female only:
Are you presently pregnant ? ________________
Pre-menstrual tension or depression
Painful menstruation - cramps
Menses excessive and prolonged
Menses scanty or missing
Vaginal discharge
Painful breasts
Menopausal hot flashes, etc
How many pregnancies? _____
Form of birth control ______________________________
PMS: explain____________________________________

Do you have a history of constipation ? __________How many bowel movements per day ? ________
Age of mattress ________ Comfortable?______ Waterbed? _______
Do you use a foam pillow ?_________ Do you sleep on : Side _____ Back _____ Stomach _____
Are you wearing: Heel lifts _____ Sole supports _____ Arch supports _____ Other:______________________

I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I also understand that I am responsible for payment if third party payment is not made.
I agree to give 24 hours notice of cancellation of appointment. If less than 24 hours notice is given, I agree that the therapist may charge for the time if unable to fill the appointment with another person. Cases of extreme emergency are considered exceptions.

Date___________________________ Signature________________________________