Case History

An accurate Health History Form is vital to ensure that it is safe for you to receive Massage Therapy. Please keep this form up to date with any changes in your health. All information gathered for this treatment is confidential, except as required or allowed by law. You will be asked to provide written authorization for release of any information. When filling out this form please take your time and print clearly. If there is not sufficient room, please use the back of this page.

Client Name_____

Street Address _____ City _____

Postal Code _____ Contact Phone # _____ _____

E-Mail Address _____

Date Of Birth _____ Age _____ Height _____

Occupation _____ Recreation Activity_____

Emergency Contact and Phone # _____

Family Physician and Phone # _____

What is your primary complaint? _____

Do you know what has caused this?_____

What have you tried for relief? _____

Please list all medications including aspirin or other over the counter pharmaceuticals.

Please list ALL past surgeries and resulting complications, if any:

Please list prior car accidents & / or significant injuries. Including physical limitations resulting from these injuries:

Have you previously received Massage Therapy before? □ Yes □ No
Are you seeing additional Health Care Professionals? □ Yes □ No
If yes, please explain

Case History

Please check all that apply

Head & Neck
- ☐ Head Trauma / Concussion
- ☐ Headaches
- ☐ Whiplash
- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Pain behind the Eyes
- ☐ Ear Problems
- ☐ Ringing in the Ears
- ☐ Hearing Loss
- ☐ Recent Dental work
- ☐ TMJ dysfunction or Grinding

Muscles & Joints
- ☐ Low Back Pain
- ☐ Degenerative Disk Disease
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Stiff / Swollen Joints
- ☐ Osteoporosis
- ☐ Bursitis
- ☐ Fractures / Dislocations
- ☐ Fibromyalgia
- ☐ Poor Posture
- ☐ Elbow / Wrist Pain
- ☐ Hip pain
- ☐ Knee Pain
- ☐ Feet trouble
- ☐ Plantar Fasciitis

Presence of:
- ☐ Internal Pins / Wires
- ☐ Artificial Joints
- ☐ Special Equipment

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Condition / Disease
- ☐ Diabetes (onset _____)
- ☐ Varicose Veins
- ☐ Stroke / CVA
- ☐ Dizziness
- ☐ Phlebitis
- ☐ Chest pain / angina
- ☐ Cold hands and / or feet
- ☐ Poor healing / Bruising
- ☐ Chronic myocardial infarction
- ☐ Fatigue
- ☐ Pacemaker

Nervous System
- ☐ Nervousness / Depressed
- ☐ Fatigued
- ☐ Insomnia
- ☐ Sciatica
- ☐ Psychosis
- ☐ Epilepsy
- ☐ Loss of Sensation
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Cerebral palsy

Immune System
- ☐ Allergies / Sinusitis
- ☐ Cancer
- ☐ AIDS / HIV
- ☐ Hepatitis A, B or C
- ☐ Anaphylactic Reaction to anything

Digestion/Elimination
- ☐ Constipation
- ☐ Diarrhea
- ☐ Liver / Gallbladder
- ☐ Kidney / Bladder
- ☐ Diverticulitis
- ☐ Ulcer
- ☐ Hiatus Hernia
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Hyperglycaemia
- ☐ Nausea / Gas

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Skin
- ☐ Sensitive
- ☐ Rashes / Ruptures
- ☐ Contagious Conditions
- ☐ Cold Sores
- ☐ Shingles

For Women
- ☐ Menopause
- ☐ Pregnant (Due _____)
- ☐ Other, please explain

Additional Comments:

Good Sleeping Habits	□ Yes	□ No
Regular Eating Habits	□ Yes	□ No
PoHigh Work / Family Stress	□ Yes	□ No
Regular Exercise	□ Yes	□ No

Last date this form was updated?

I have answered the above and to the best of my knowledge all information is correct and accurate.

Date _____ **Signature** _____