

# Confidential Case History

Date of first visit \_\_\_\_\_ Email address \_\_\_\_\_  
Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Age \_\_\_\_ Date of birth \_\_\_\_\_ M/F married \_\_\_\_ single \_\_\_\_ divorced \_\_\_\_  
widowed \_\_\_\_ partner \_\_\_\_ no. of children \_\_\_\_  
Occupation \_\_\_\_\_ How did you hear about us? \_\_\_\_\_  
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? Yes/No  
Does it interfere with recreation? Yes/No  
What do you believe is wrong with you? \_\_\_\_\_  
What have you done to get relief? \_\_\_\_\_  
Has there been a medical diagnosis? Yes/No Exam? Yes/No Blood work? Yes/No  
X-rays? Yes/No Other? \_\_\_\_\_  
What was the diagnosis? \_\_\_\_\_ By whom? \_\_\_\_\_  
Other areas of pain or concern: \_\_\_\_\_

## **PAST HISTORY:**

Have you ever had a similar problem before? Yes/No When? \_\_\_\_\_  
What caused those episodes? \_\_\_\_\_  
What relieved them? \_\_\_\_\_  
What was the previous diagnosis? \_\_\_\_\_  
What treatments? \_\_\_\_\_  
Did they help? Yes/No Have you had massage therapy? Yes/No  
Are you presently under a doctor's care? Yes/No  
If so, for what condition? \_\_\_\_\_

Name of physician \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Phone \_\_\_\_\_  
Are you taking any: Medications -- list \_\_\_\_\_

( ) Laxatives ( ) Sedatives ( ) Sleeping pills ( ) Insulin ( ) Blood thinners  
( ) Aspirin ( ) Vitamins ( ) Herbs ( ) Minerals ( ) Birth control pills  
( ) Other

Indicate the following habits with H=Heavy M=Moderate L=Light N=None

Alcohol \_\_\_\_ Coffee \_\_\_\_ Tea \_\_\_\_ Tobacco \_\_\_\_ Colas \_\_\_\_  
White flour products \_\_\_\_ Exercise \_\_\_\_ Sugared products \_\_\_\_

Cravings \_\_\_\_\_

Previous operations \_\_\_\_\_

Previous broken bones \_\_\_\_\_

Previous accidents or injuries \_\_\_\_\_

Do you bruise easily? \_\_\_\_\_

**Circle** any of the following you are **CURRENTLY** having difficulty with.  
**Underline** any for which you have had **PAST** problems.

- |                        |                                |                        |
|------------------------|--------------------------------|------------------------|
| Headaches              | Grating in neck                | Cold sweats            |
| Shooting pains in head | Tightness in shoulder muscles  | Liver trouble          |
| Sinus trouble          | Neuritis in shoulders & arms   | Gallbladder trouble    |
| Loss of smell          | Pins & needles in arms & hands | Indigestion            |
| Loss of taste          | Cold hands                     | Instestinal gas        |
| Tightness in throat    | Chest pains                    | Constipation           |
| Inflammation of throat | Shortness of breath            | Kidney trouble         |
| Thyroid trouble        | T.B.                           | Bladder trouble        |
| Face flushed           | Heart pain                     | Diabetes               |
| Twitching of face      | Heart palpitations             | Cancer                 |
| Loss of memory         | Heart attack                   | Sleeping problems      |
| Fatigue                | High blood pressure            | Painful joints         |
| Depression             | Low blood pressure             | Swollen joints         |
| Head feels too heavy   | Anemia                         | Arthritis              |
| Dizziness              | Blood clots/Phlebitis          | Osteoporosis           |
| Fainting               | Rheumatic fever                | Herniated/bulging disk |
| Loss of balance        | Nervous stomach                | Pinched nerve in back  |
| Ringing in ears        | Ulcers                         | Pins & needles in legs |
| Wear glasses           | Nervousness                    | Swollen ankles         |
| Light bothers eyes     | Inner tension                  | Cold feet              |
| Hayfever               | Skin disorders                 | Pains in legs & feet   |
| Asthma                 | Varicose veins                 | Numb hands or feet     |
| Epilepsy               | Low back pain                  | Sciatica               |
| Excessive perspiration | Middle back pain               | Other _____            |
| Muscle spasm in neck   | Upper back pain                |                        |

<p><b>Male only</b></p> <p>Burning during urination</p> <p>History of prostate trouble</p> <p>Urination difficult or dribbling</p> <p>Frequent night urination</p> <p>Pain in the groin area</p> <p>Diminished sex drive</p> <p>Burning or pain during orgasm</p>	<p><b>Female only</b></p> <p>ARE YOU PRESENTLY PREGNANT? _____</p> <p>Premenstrual tension or depression</p> <p>Painful menstruation - cramps</p> <p>Menses excessive and/or prolonged</p> <p>Menses scanty or missing</p> <p>Vaginal discharge</p> <p>Painful breasts</p> <p>Menopausal hot flashes, etc.</p> <p>How many pregnancies _____</p> <p>Form of birth control _____</p> <p>PMS: Explain _____</p> <p>_____</p>
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Do you have a history of constipation? \_\_\_\_\_ How many bowel movements per day? \_\_\_\_\_

Age of mattress \_\_\_\_\_ Comfortable/uncomfortable Waterbed \_\_\_\_\_

Do you use a foam pillow? \_\_\_\_\_ Do you sleep on: side \_\_\_\_ back \_\_\_\_ stomach \_\_\_\_

Are you wearing: Heel lifts sole supports arch supports inner soles

**Client's payment agreement: I understand that fees are due at the time of treatment unless arrangements are made. I also understand that if I cancel an appointment within 24 hours of the visit, the full price of the visit will be charged.**

Date \_\_\_\_\_ Signature \_\_\_\_\_