

CONFIDENTIAL CASE HISTORY

Name _____ Phone _____ Cell _____

Address _____ City _____ State _____ Zip _____

Age _____ Date of Birth _____ M _____ F _____ Marital Status _____ # of Children _____

Occupation _____ Date of First Visit _____

Have you had massage before? _____ Last massage was (approx) _____

Major area or pain or concern _____

When did you first notice it? _____ What brought it on? _____

What activities aggravate it? _____

Is this condition getting worse? _____ Does it interfere with work? _____ Sleep? _____ Other _____

What have you done to bring relief? _____

Is there a medical diagnosis? _____ Exam? _____ X-rays? _____ Other _____

Other areas of pain or concern _____

PAST HISTORY

Have you ever had a similar problem before? _____ When? _____ What relieved it? _____

Are you presently under a doctor's care? _____ For what condition? _____

Name of Physician _____ City _____ State _____

Please list medications you are on _____

Laxatives _____ Anxiety Meds _____ Sleeping pills _____ Insulin _____ Blood Thinners _____ Aspirin _____

Vitamins _____ Herbs _____ Minerals _____ Birth Control Pills _____ Hormone Replacement: specify _____

Please indicate with H-heavy M-moderate L-light N-none

Coffee _____ Tea _____ Alcohol _____ Tobacco _____ Colas _____ Sugar products _____ NutraSweet _____

Exercise _____ Amount of Water consumed per day _____

Previous surgeries with age _____

Previous broken bones with age _____

Previous injuries or accidents with age _____

What is your main objective for receiving Massage Therapy?

_____ Stress Reduction _____ Relaxation _____ Pain Relief

Please take a moment to read the following information and sign where indicated: If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided. I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that this work should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and nothing said in the course of the session should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions accurately. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part, should I forget to do so. It is understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the appointment.

Client Signature _____ Date _____

All information is confidential unless an authorization for release of information is given by client.

Kindly make all cancellations with 24 hours notice. Thank you.

MARK YOUR AREAS OF PAIN ON THE FIGURES

