

Case History Outline

*mandatory fields for file purposes

*Name _____

*Date _____

*Signature: _____

*Telephone: _____

Please confirm my appointments at (circle): Home / Work / Mobile/ Email

*Alternate number: _____ ext _____

*Address: _____
*STREET CITY

e: _____
EMAIL ADDRESS - CONSENT

*Date of Birth: _____ Month / Day / Year Weight: _____ Height: _____ Occupation: _____

Where did you hear about our clinic? _____
PLEASE SPECIFY (ARTICLE, NAME OF FRIEND, NAME OF DOCTOR...ETC.)

What brings you in for a massage? _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

high blood pressure
 low blood pressure
 chronic congestive heart failure
 heart attack
 phlebitis / varicose veins
 stroke/CVA
 pacemaker or similar device
 heart disease

is there a family history of any of the above? Yes No

Respiratory

chronic cough
 shortness of breath
 bronchitis
 asthma
 emphysema

is there a family history of any of the above? Yes No

Infections

hepatitis
 skin conditions
 TB
 HIV
 herpes

Other Conditions

loss of sensation, where? _____
 diabetes, onset: _____
 allergies/hypersensitivity to what? _____
type of reaction: _____
 epilepsy
 cancer, where? _____
 skin conditions, what? _____
 arthritis

is there a family history of arthritis?
 Yes No

Head/Neck

history of headaches
 history of migraines
 vision problems
 vision loss
 ear problems
 hearing loss

Women

pregnant, due: _____
 gynaecological conditions, what? _____

Overall, how is your general health?

Primary Care Physician:

Address:

Current Medications:

 condition it treats: _____

Are you currently receiving treatment from another health care professional? Yes No
 If yes, for what? _____

Surgery – date _____
 nature: _____

Injury – date _____
 nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) Yes No
 what? _____

Do you have any internal pins, wires, artificial joints or special equipment? Yes No
 what? _____
 where? _____

What is the reason you are seeking massage therapy?
 Please include the location of any tissue or joint discomfort.

Notes:

Date of initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____