# Case History Outline

**Name** _____ **Telephone:** _____

**Address:** _____ _____ _____ **e:** _____
*STREET *CITY *POSTAL CODE EMAIL ADDRESS - CONSENT

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

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

What brings you in for a massage? _____

Health History: Please check the symptoms or conditions that you are currently experiencing or have experienced often in the past

**Head/Neck**
- ☐ History of Headaches
Type:_____
- ☐ Vision problems
- ☐ Contact lenses
- ☐ Earaches

**Respiratory**
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Smoker
- ☐ Breathing problems
Type: _____

**Cardiovascular**
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Heart disease
- ☐ Phlebitis
- ☐ Stroke
- ☐ Varicose veins
Dr. diagnosed? YES / NO

**Other healthcare**
- ☐ Chiropractic
- ☐ Physiotherapy
- ☐ Psychotherapy
- ☐ Regular Exercise
- ☐ Massage

**Skin**
- ☐ Skin Conditions
Type:_____
- ☐ Bruise easily

**Other Conditions**
- ☐ Difficult digestion
- ☐ Constipation
- ☐ Liver _____
- ☐ Gall bladder _____
- ☐ Kidney
- ☐ Bladder _____
- ☐ Diabetes, onset: _____
- ☐ Sinus _____
- ☐ Allergies _____
- ☐ Insomnia
- ☐ Cancer _____
- ☐ Family history of Arthritis
Dr. diagnosed? YES / NO
Affected areas_____
_____
- ☐ Epilepsy

**Infections**
- ☐ Herpes
- ☐ Hepatitis
- ☐ Plantar wart
- ☐ TB
- ☐ HIV, AIDS
- ☐ Other: _____

**Women**
- ☐ Menstrual problems
Type: _____
- ☐ Gynecological surgery
- ☐ Pregnant : due___/___/___
D M Y
- ☐ # of children:_____
- ☐ Menopausal problems

**Muscle/Joint**
- ☐ Neck
- ☐ Low back
- ☐ Mid-back
- ☐ Upper back
- ☐ Shoulders
- ☐ Leg: Left / Right
- ☐ Knee: Left/Right
- ☐ Other:_____

**Surgery**
Type: _____
Date: _____
Current symptoms: _____
_____

**Injury**
Type: _____
Date: _____
Current symptoms: _____
_____

**Family Doctor:** _____
Address: _____ PH#_____
Date of last visit: ___/___/___ reason:_____
_____

**Current Medications**

| Name | Reason |
|---|---|
| | |
| | |
| | |

Are there any other medical conditions? (eg osteoporosis, hemophilia, etc.)
_____
_____

Do you have any internal pins, wires, artificial joints or special equipment?
_____

**Special Notes** _____
_____