Massage Therapy Case History (female)

Name _____ Birthdate _____

Street, City and Postal Code _____

Phone home _____ Email or cell _____

Physician name & address _____

Auto or Work Claim? ❒ Yes Claim # _____ Employee health benefits? ❒ Yes

Occupation _____ Referred by _____

Reason for visit today? _____ Prior massage therapy? ❒ Yes

No Pain

0

1

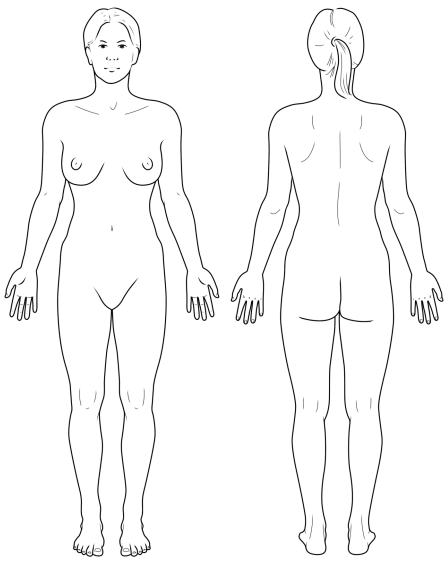
2

3

4

5

Severe



Symptoms / Conditions - Please indicate:
C – Current P – Past F- Family history

___ Signs of inflammation or infection
___ Tension headaches or migraines
___ "Pins & needles" or numbness
___ Strength or sensory loss of any kind
___ Muscle or joint pain or stiffness
___ Hearing or vision loss, balance / coordination
___ Cardiovascular disease. Pacemaker? ❒ Yes
___ High or low blood pressure
___ Diabetes, or other hormone disorders
___ Broken bones, artificial joints, pins or plates
___ Osteo- or rheumatoid arthritis, bone disease
___ Cuts, warts, open sores, skin irritation
___ Bronchitis, emphysema or asthma
___ Tuberculosis, hepatitis, herpes or HIV
___ Allergies, hyper-sensitivities, anaphylaxis
___ Cancer or auto-immune disorder
___ Multiple sclerosis, epilepsy, nerve disorder
___ Anxiety, panic attacks or mood disorder
___ Gynecologic / other conditions not listed:

_____

Describe your general health

Recent tests/screenings (eg: blood, x-ray, MRI)? ❒ Yes

Medications and supplements? Please list:

Are you physically active? ❒ Yes Sleep well? ❒ Yes

♀Women – pregnant? ❒ Yes Trimester? 1 2 3

How do your symptoms affect your recreation, work duties and social interaction?

Please list nature and date of surgeries or severe trauma:

Other therapies/treatments currently receiving?

"*I understand my information is held private and confidential and released only with my permission or as required by law*."
(please sign & date)

_____ _____

(Practitioner) Last update: _____