

## CONFIDENTIAL PATIENT CASE HISTORY FORM

### PERSONAL CONTACT INFORMATION

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_\_ Home Telephone Number: \_\_\_\_\_  
 \_\_\_\_\_ Work Telephone Number: \_\_\_\_\_  
 \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_  
 \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Who referred you? \_\_\_\_\_  
 Primary Complaint: \_\_\_\_\_ Address: \_\_\_\_\_

### HEALTH HISTORY

Please indicate conditions you are experiencing, or have experienced. Check all the conditions that are applicable to you.  
 What is your general Health Status? \_\_\_\_\_

**Musculo-Skeletal**

- headaches and/or trauma
- jaw pain/TMJ
- neck and/or shoulder
- arm pain Right and/or Left
- upper mid back
- low back/hip
- leg pain Right and/or Left
- knee pain Right and/or Left
- tendonitis, bursitis
- sprains, strains
- other

**Pathologies**

- Liver
- Kidney
- Bladder
- Diabetes
- Cancer
- Epilepsy
- Other

**Cardiovascular**

- high blood pressure
- low blood pressure
- heart disease
- varicosities
- breathing difficulties
- chronic cough
- sinus problems
- allergies
- other

**Nervous System**

- Chronic pain
- Numbness, tingling
- Fatigue
- Insomnia
- Other

**Digestive**

- Constipation
- Irritable bowel syndrome
- Other \_\_\_\_\_

**Skin**

- Allergies
- Infections
- Rashes
- Wounds, scars
- Bruise easily
- Other

**Infections**

- Herpes
- Hepatitis
- Plantar warts
- TB
- HIV, AIDS
- Other

**Women**

- Menstrual problems
- Gynaecological surgeries
- Pregnancy due date \_\_\_\_\_
- other

Current medications: \_\_\_\_\_ What condition does it treat? \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Address: \_\_\_\_\_  
 Surgery: \_\_\_\_\_ Injury: \_\_\_\_\_  
 Date: \_\_\_\_\_ Date: \_\_\_\_\_  
 Nature: \_\_\_\_\_ Nature: \_\_\_\_\_  
 Present involvement in Other Health Care? If yes, please specify: \_\_\_\_\_

Of Special Note: Please indicate the presence of internal pins, wires, artificial joints, special equipment: \_\_\_\_\_

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**NATURE OF COMPLAINT**

Please indicate the level of pain/discomfort that you are experiencing with your condition.

Can you describe the pain/discomfort? \_\_\_\_\_

What is the area of complaint? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Is it worse or staying the same? \_\_\_\_\_

Is this condition interfering with: (please circle)    Work                      Sleep                      Daily Routine                      Activities

Please Specify: \_\_\_\_\_

Have you seen any other Health Professional regarding this problem? If yes, who? \_\_\_\_\_

What was the target treatment plan? \_\_\_\_\_

Was it successful? Did it bring you any relief? \_\_\_\_\_

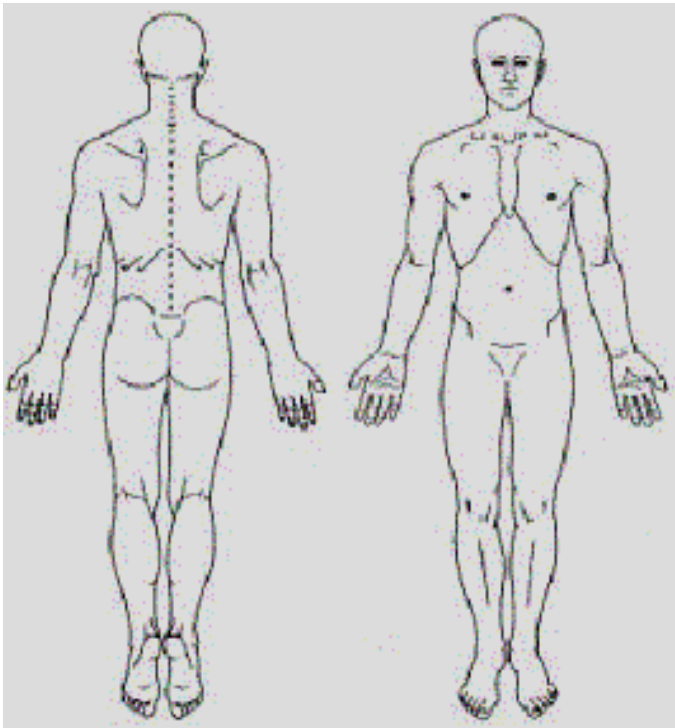
From a pain scale of one to ten, ten being the worst pain, how uncomfortable do you feel? \_\_\_\_\_

Does the pain/discomfort radiate? If yes, where to? \_\_\_\_\_

Is there anything that will relieve the pain? For example, hot or cold compresses. \_\_\_\_\_

**DESCRIPTION**

Please indicate the area of discomfort with an "X" and briefly describe your condition as best as you can in the space below.



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please note that a 24-hour cancellation notice is required, otherwise a \$35.00 (thirty-five dollars) fee will be charged.**

I have state all medical conditions and will update my therapist of any changes in my health status. I have the right to stop, change or request modification for my treatment within the scope of practice of the therapist, and consent to be treated for therapeutic massage.

Name: \_\_\_\_\_ Date: \_\_\_\_\_