

Massage Therapy Confidential Case History

Name _____ Date _____
Address _____
City _____ Postal Code _____
Home Phone () _____ Work Phone () _____
Cell Phone () _____ Email _____
Occupation _____ Employer _____
Date of Birth (m) _____ / (d) _____ / (y) _____ Gender M F Height _____ Weight _____
Name of Physician _____ Chiropractor _____
Physiotherapist _____ Other(s) _____

Who referred you to our clinic? (name of friend, family, Dr?) _____

What are you looking to get out of your Massage Treatment (ie. Pain relief, maintenance, natal care)? _____

Have you previously received Massage Therapy? Yes _____ No _____ If yes, when _____

Reason for previous massage treatment _____

What are your expectations from the treatment? _____

Please list any diagnosed conditions _____

Please list any previous injuries and surgeries _____

Please list any medications which you are currently taking _____

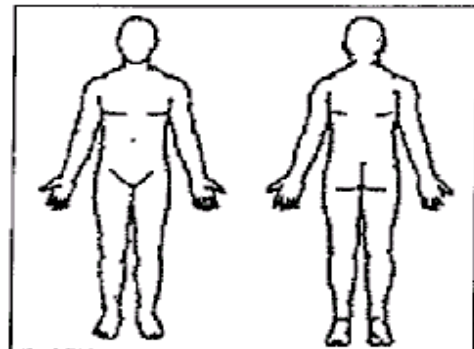
Have you been injured in a motor vehicle accident within the past 2 years? Yes _____ No _____

Physical Concerns

Please circle appropriate response below
(5=excellent/high, 1=poor/low)

- a) Overall physical health 5 4 3 2 1
- b) Physical activity 5 4 3 2 1
- c) Energy Level 5 4 3 2 1
- d) Current stress level 5 4 3 2 1
- e) Ability to relax 5 4 3 2 1
- f) Ability to sleep 5 4 3 2 1
- g) Emotional wellness 5 4 3 2 1
- h) Work environment 5 4 3 2 1

Please circle areas on the figures below
that are painful or require treatment



Front

Back

Since Massage Therapy affects various body systems, it is important to have you complete a comprehensive medical history. Please indicate any of the following conditions which apply to you.



Head

- Headaches, type _____
- Vision problems
- Sinus problems
- Dizziness/fainting
- TMJ dysfunction
- Hearing problems
- Head trauma
- Other _____

Digestive/ Uro-genital

- Abdominal pain
- Digestive problems
- Constipation/diarrhea
- Nausea
- Gas
- Kidney/Bladder problems
- Liver problems
- Gallbladder problem
- Urinary problems
- Ulcers
- Diabetes
- Excessive/Poor appetite
- Hepatitis

Muscles/Joints

- Osteoarthritis
- Rheumatoid arthritis
- Muscle cramps
- Limitation of movement
- Pain
- Stiffness
- Swelling
- Other _____

Nervous

- Neural disorders
- Numbness/tingling
- Paralysis
- Other _____

Skin

- Skin disorders
- Bruises easily
- Skin sensitivity
- Contagious skin condition
- Other _____

Cardiovascular

- High blood pressure
- Low blood pressure
- Heart condition
- Heart murmur
- Heart attack/stroke
- Arteriosclerosis
- Atherosclerosis
- Poor circulation
- Varicose veins
- Phlebitis
- Other _____

Other Conditions

- Frequent colds
- Cancer
- AIDS, HIV
- Epilepsy
- Thyroid problems
- Allergies
- Sleep disorders
- Hernia
- _____

I understand that the information that I provide on this form will be confidential and will be used for the sole purpose of the professional Massage Therapists' clinical records.

I hereby release the Massage Therapist and the Oliver Chiropractic Wellness Clinic (OCWC) from any and all liability due to problems arising from the therapy as a result of information not given, or incorrectly given, in this case history. I also agree to advise the Massage Therapist of any pertinent condition that may arise or change during the treatment period.

In our continuing effort to provide caring and timely service we make every effort to place a reminder call the day prior to your appointment. Please remember these calls are a **COURTESY** and it still remains your responsibility to notify the clinic if you are unable to make your appointment. OCWC will bill for any **MISSED, CANCELLED** or **RESCHEDULED** appointment if **24 HOURS** notice is not given.

I understand and agree to the above terms and to the cancellation policy explained and set forth by Oliver Chiropractic Wellness Clinic.

Date

Client's Signature

