Massage Therapy
Confidential Case History

Name _____

Address_____ Postal Code_____

Home Phone ( )_____ Work Phone ( )_____

Cell Phone ( )_____ Email_____

Occupation_____ Employer_____

Date of Birth: ____/_____/_____ Gender: M F Height_____ Weight_____

d m y

Name of Physician _____ Chiropractor_____

Physiotherapist_____ Other(s) _____

Recommended by (Please be specific) _____

Reason for visit _____

Have you previously received Massage Therapy? Yes_____ No_____ If yes, when_____

Reason for previous 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_____

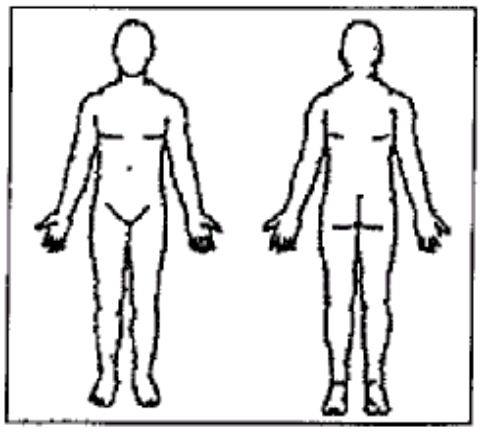
If yes, is your claim still open? Yes_____ No_____

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

Physical Concerns

Please indicate on the figures below the areas that 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 appetite
- ○ Poor appetite
- ○ Hepatitis
- ○ Other_____

Muscles/Joints
- ○ Osteoarthritis
- ○ Rheumatoid arthritis
- ○ Muscle cramps
- ○ Limitation or 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 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.

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

_____ _____

Date **Client's Signature**