Massage Therapy Confidential Case History

Name:	Date of Birth:
Address:	Occupation:
	Phone (home):
Email:	Phone (work):
Primary Care Physician:	Phone:
Physician's Address:	
Chiropractor:	Phone:
Physiotherapist:	Phone:

Chief Complaint:
Other Complaints:
Please list relevant injuries, illnesses or surgeries and provide dates:

Health History: Please indicate conditions you are experiencing or have experienced.

Respiratory	**Other Conditions**	**Infections**
□ chronic cough	□ cold feet/hands	□ hepatitis
□ shortness of breath	□ dizziness	□ skin conditions
□ bronchitis	□ loss of sensation	□ TB
□ asthma	□ diabetes	□ HIV
□ emphysema	onset?	**Soft Tissue/Joint Discomfort**
Cardiovascular	□ allergies	□ neck
□ high blood pressure	to?	□ low back
□ low blood pressure	□ skin irritation	□ mid back
□ CCHF	□ epilepsy	□ upper back
□ heart attack	□ cancer	□ shoulders
□ phlebitis	□ arthritis	□ arms
□ stroke/CVA	□ fibromyalgia	□ legs
□ pacemaker or similar device	□ chronic fatigue syndrome	□ knees
□ heart disease	□ vision problems/loss	□ other
	□ hearing problems/loss	**Women**
	□ headaches	□ pregnant (due)
	type?	□ painful menstruation
	□ insomnia/restless sleep	□ other
	□ varicose veins	
	□ surgical pins and/or metal	

Please list any medications:

NOTE: A 24-hour notice is required for cancellation of an appointment. Otherwise, you will be charged for the missed massage.

Please sign and date to confirm your consent to receive massage therapy.

Signature: ______________________________ Date: ________________________