# CONFIDENTIAL PATIENT CASE HISTORY

Name: ______________________________ Date: ______________

**Address:** ____________________________________________
Residence and Mailing | City | Province/State | Postal Code/Zip

Cell Phone Number: (    ) ______________ Work Telephone Number: (    ) ______________

Email: ______________________ Birth date: ______________

Occupation: ______________ Employed by: ______________________

Do you have insurance benefits? ☐Yes ☐No Company: ______________

Have you had previous massage therapy care? ☐Yes ☐No

When was the last time you had a massage? ______________________

Do you have an existing massage therapist? ☐Yes ☐No

Medical Doctor's name and phone number: ______________________

Whom may we thank for referring you to our office? ______________________

Please check (√) all symptoms you have had in the past year even if they do not seem related to your current problem.

- ☐ Headaches
- ☐ Neck Pain/ Stiffness
- ☐ Pins & Needles in Arms
- ☐ Pins & Needles in Legs
- ☐ Numbness in upper limb
- ☐ Numbness in lower limb
- ☐ Hypersensitive Eyes
- ☐ Buzzing/ringing in Ears
- ☐ Irritability
- ☐ Mood Swings
- ☐ Severe Nervousness
- ☐ Fatigue
- ☐ Depression
- ☐ Constipation
- ☐ Diarrhea
- ☐ Significant Tension
- ☐ Fainting
- ☐ Dizziness
- ☐ Back Pain
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Problem Urinating
- ☐ Heartburn
- ☐ Ulcers
- ☐ Upset Stomach
- ☐ Loss of Taste
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Severe Menstrual Pain
- ☐ Menstrual Irregularity
- ☐ Fever in the past month
- ☐ Hot Flashes
- ☐ Sleeping Problems
- ☐ Cold Sweats

Please note any major illnesses you have had: ☐Heart disease ☐Cancer ☐Diabetes Other: __________
______________________________________________

Please list any major accidents or surgeries you have had and when you had them: ______________
______________________________________________

Please list any medications you are taking: ______________________

How would you like us to contact you?
- ☐ Text
- ☐ E-mail
- ☐ Cell Phone
- ☐ Home Phone

Please note it is your responsibility to confirm your insurance coverage, including: extent, limit per visit, deductible, and account balance to date. All accounts must be paid in full within one month of treatment date.
We have a no show fee of $25.00. The fee must be paid in cash and cannot be claimed through insurance.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me/my child for further evaluation.

If you have been injured at work or involved in a recent automobile collision, please let us know so we can arrange to bill on your behalf.

Signature of Patient/Legal Guardian: ______________________ Date: ______________