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.

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.

Signature of Patient/Legal Guardian: ____________________ Date: __________