CASE HISTORY

Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ Cell Phone _____

State, Zip _____ E-mail _____

Date of Birth _____ Age _____ ❑ Male ❑ Female Marital Status _____

Number of Children _____ Occupation _ _____

Social Security Number _____ Referred by _____

Who is responsible for this account? _____

1. Present Symptom: What is your major complaint? _____

   _____

2. Minor Complaints: Other areas of pain or concern? _____

   _____

3. When did you first notice major complaint? _____
4. What brought it on? _____
5. What activities aggravate condition? _____
6. Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes & goes
7. Is this condition interfering with your: work _____ sleep _____ daily routine _____
8. What do you believe is wrong with you? _____
9. What have you done to get relief? _____
10. Has there been a medical diagnosis? ❑ Yes ❑ No If yes, what was it? _____

    By whom? _____ Address _____

    X-rays _____ Blood work _____

11. If you are currently seeing a chiropractor, what is the doctor's name and location of practice?

    _____

Are you taking any of the following?

- ❑ Laxatives
- ❑ Aspirins
- ❑ Sleeping Pills
- ❑ Insulin
- ❑ Sedatives
- ❑ Vitamins
- ❑ Minerals
- ❑ Herbs

Habits	*Heavy*	*Moderate*	*Light*	*None*
Alcohol	____	_____	____	_____
Coffee/Tea	____	_____	____	_____
Soda	____	_____	____	_____
Tobacco	____	_____	____	_____
Sugar	____	_____	____	_____
Exercise	____	_____	____	_____

Have you had any operations? ❑ Yes ❑ No

Describe briefly _____

_____

Have you broken any bones? ❑ Yes ❑ No

Describe briefly _____

_____

Have you been in an accident? ❑ Yes ❑ No

If yes, did you receive whiplash? ❑ Yes ❑ No

What do you expect from your visits here?

_____

_____

_____

_____

Do you have any difficulty with the following?

- ❑ Headaches
- ❑ Shooting head pains
- ❑ Clenching jaw
- ❑ Grinding teeth
- ❑ Sinus trouble
- ❑ Loss of smell
- ❑ Hayfever
- ❑ Asthma
- ❑ Loss of taste
- ❑ Tightness in throat
- ❑ Inflammation of throat
- ❑ Thyroid trouble
- ❑ Face flushed
- ❑ Twitching of face
- ❑ Loss of memory
- ❑ Fatigue/Lack of energy
- ❑ Tire too easily
- ❑ Sleeping problems
- ❑ Depression
- ❑ Nervousness
- ❑ Head feels too heavy
- ❑ Dizziness
- ❑ Fainting
- ❑ Loss of balance
- ❑ Ringing in ears
- ❑ Wearing glasses/contacts
- ❑ Lights bother eyes
- ❑ Muscle spasms in neck
- ❑ Grating in neck
- ❑ Tightness of shoulder muscles
- ❑ Neuritis in shoulder & arms
- ❑ Pins & needles in arms/hands
- ❑ Cold hands
- ❑ Painful joints
- ❑ Swollen joints
- ❑ Arthritis
- ❑ Chest pains
- ❑ Shortness of breath
- ❑ Heart pain
- ❑ Heart palpitations
- ❑ Heart attacks
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Anemia
- ❑ Rheumatic fever
- ❑ Slipped disc
- ❑ Pinched nerves in back
- ❑ Sacroiliac or low back pain
- ❑ Sciatica
- ❑ Nervous stomach
- ❑ Stomach trouble
- ❑ Ulcers
- ❑ Nerves & nervousness
- ❑ Inner tension
- ❑ Irritability
- ❑ Cold sweats
- ❑ Liver trouble
- ❑ Gall bladder trouble
- ❑ Indigestion
- ❑ Intestinal pain
- ❑ Kidney trouble
- ❑ Bladder trouble
- ❑ Diabetes
- ❑ Cancer
- ❑ Pins & needles in legs
- ❑ Swollen ankles
- ❑ Cold feet
- ❑ Pains in legs & feet

Male Only:

- ❑ History of prostate trouble
- ❑ Urination difficult or dribbling
- ❑ Frequent night urination
- ❑ Burning upon urination
- ❑ Pain in the shoulders
- ❑ Persistent abdominal pain
- ❑ Pain on inside of legs or heels
- ❑ Pain in groin area
- ❑ Sacroiliac or low back pain
- ❑ Burning or pain during orgasm

Female Only:

- ❑ Pre-menstrual tension or depression
- ❑ Painful menstruation - cramps
- ❑ Menstruation excessive or prolonged
- ❑ Menstruation scanty or missing
- ❑ Vaginal discharge
- ❑ Painful breasts
- ❑ Menopausal hot flashes, etc.
- ❑ Melancholia of long standing
- ❑ Have an I.U.D. or diaphragm
- ❑ Take birth control pills

How many pregnancies? _____

How many bowel movements daily? _____ Do you have a history of constipation? _____

If yes, what have you done to relieve it?_____

Mattress or waterbed? _____ If mattress, age of mattress _____

Do you use a foam pillow? _____ Do you sleep on: ❑ Side ❑ Back ❑ Stomach

Are you wearing: ❑ Heel lifts ❑ Sole lifts ❑ Arch supports ❑ Inner soles

It has been made clear to me that massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailments that I might have. Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature _____ Date _____