Healthy Heights Massage Clinic

Case History Form

Please note that the information you give to us is confidential and it will help us to ensure a safe and effective treatment plan that will be specifically for you.

Name (please print):_____ Date:_____

Address:_____ City:_____ Postal Code:_____

Phone: Home_____ Business_____ Cell_____

Date of Birth: ____/_____/_____ Sex: M F Height & Weight:_____

Occupation:_____ Regular hobbies/sports/activities:_____

Physician name/address/phone:_____

Current Medications (including nonprescription):_____

_____

Have you recently been in a motor vehicle accident / work related injury to which you will be making claim? YES ☐ NO ☐

Allergies?_____

Who referred you to this clinic?_____

Have you had a massage treatment before? YES ☐ NO ☐

What is you primary complaint?_____

Can you describe it? DULL SHARP SHOOTING ACHY NUMB TINGLING STIFF

Pain scale: (low) 1--------5--------10 (high) Does it radiate anywhere?_____

Does anything aggravate your symptoms?_____

When did your symptoms begin?_____

Is this condition interfering with: WORK SLEEP DAILY ROUTINE ACTIVITIES

(please explain)_____

Have you seen any other health care practitioner concerning this complaint?
Medical Dr. ☐ Chiropractor ☐ Physiotherapist ☐ Massage Therapist ☐ Other ☐ _____

Have they provided results?_____

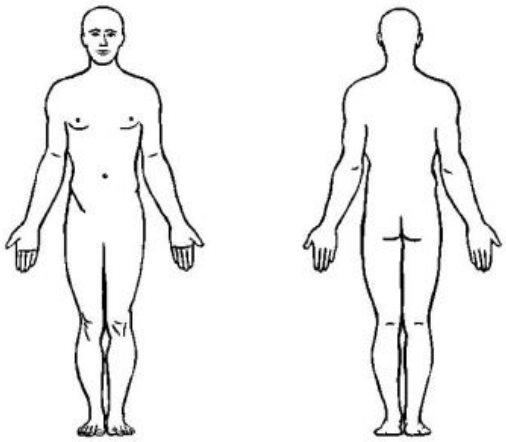
Surgery/injuries/hospitalization: (date, past & current symptoms)_____

_____

Please tick all that apply.

HEAD / NECK	**SKIN**	**DIGESTIVE / URINARY**	**CARDIOVASCULAR**
Headaches ☐ Migraines ☐ Sinus problems ☐ Hearing imparted ☐ Vision impaired ☐ Speech impaired ☐ Jaw Pain / TMJ ☐ Whiplash ☐ Dizziness/light headed ☐ Loss of balance☐	Infections ☐ Ulcers ☐ Rashes ☐ Psoriasis ☐ Bruise easily ☐ Eczema ☐ Sensitivity ☐ Wounds ☐ Athelet's foot ☐ Cold Sores ☐ Planter warts ☐ Other …	Constipation ☐ Crohn's disease ☐ Irritable bowel ☐ Ulcers ☐ Hernia ☐ Liver / Gallbladder ☐ Kidney / Urinary ☐ Diabetes (Type) ☐	High blood pressure ☐ Low blood pressure ☐ Heart disease / Stroke ☐ Poor circulation ☐ Phlebitis ☐ Varicose Veins ☐ Pacemaker ☐ Arteriosclerosis ☐ Irregular heart beat Blood clots/ DVT Rheumatic fever
RESPIRATORY Asthma ☐ Chronic cough ☐ Shortness of breath ☐ Bronchitis ☐ Emphysema ☐ Smoker ☐ **GYNOCOLOGICAL** Endometriosis ☐ Dysmenorrhea ☐ Menopause ☐ Pregnant ☐	**MUSCLE / JOINTS** Osteoarthritis ☐ Osteoporosis ☐ Rheumatoid ☐ Fractures ☐ Tendonitis ☐ Back Injury ☐ Neck Injury ☐ Shoulder Injury ☐ Arm/Hand/Elbow ☐ Leg/Knee/Foot ☐ Hip☐ Pins/Wires ☐ Artificial joints ☐	**LYMPHATIC** Oedema ☐ Lymphoedema ☐ Hodgkin's disease ☐ Leukemia ☐ **NERVE INVOLVMENT** Numbness ☐ Pinched nerve ☐ Pins & Needles ☐ Carpal Tunnel ☐ Herniated disk ☐ Sciatica ☐	**OTHER** Multiple Sclerosis ☐ Paget's disease ☐ Epilepsy ☐ Parkinson's disease ☐ Thyroid problems ☐ Tumors/growths ☐ Cancer ☐

Please mark any area(s) that you experience pain



TREATMENT PLAN (practitioner use) First Appointment…

CONSENT/ AUTHORISATION

I certify that the information given is to the best of my knowledge correct. I will inform the practitioner of any changes in the future in my health status. I have discussed my risks with my practitioner, and been given the opportunity to ask questions. Having discussed and understood the treatment plan, I grant permission for care to proceed.

_____ _____

Date Client's Signature

Healthy Heights Massage Clinic

CLIENT RECORD SHEET

Appointment _____ Date _____

Feedback

Visual Observations

Adverse Reactions

Referrals

Recommendations / Suggestions

Notes …