Confidential Case History

Massage &/or Acupuncture

Date:_____

For your information

An accurate health history is important to ensure that it is safe for you to receive a massage/ acupuncture treatment. If your health status changes in the future, please let your therapist know. All information for this treatment is confidential except as required by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Last Name		First Name	
Address		City	Postal Code
Home Number	Cell Number	Occupation	
Date of Birth(M/D/Y)	Gender	Is this a motor vehicle accident?	
Marital Status	Number of Children	Have you ever had a massage before?	
Email Address		Would you like an email reminder? Yes ☐ No ☐	
Emergency Contact Name & Number			

Current Health Conditions

What brings you in?	
When did it start	Have you had a similar problem in the past? Yes ☐ No ☐
The Condition is: (circle applicable) Constant comes & goes getting worse	The condition is interfering with: (circle applicable) Work sleep daily routine sports
What makes your condition: Better? Worse?	
Any major illnesses or surgeries?	
Have you ever been in a car accident, if yes when?	
Do you have any other health issues/complaints?	

Any medications or supplements you're currently taking?	What conditions do these treat?

Continue on back

Health History

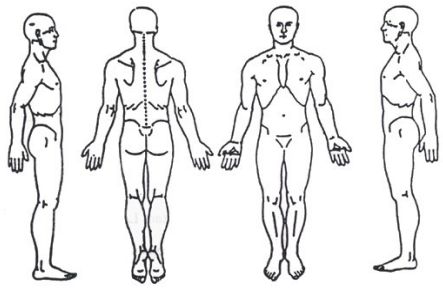
Please check off conditions you are experiencing now or have in the past:

General	Respiratory	Cardiovascular	Skin
☐ Allergies ☐ Convulsions ☐ Dizziness ☐ Fatigue/tiredness ☐ Headaches ☐ Fibromyalgia ☐ Chronic fatigue ☐ Fainting	☐ Chronic cough ☐ Shortness of breath ☐ Bronchitis ☐ Asthma ☐ Emphysema	☐ High/low blood pressure ☐ Chronic congestive heart failure ☐ Heart disease/attack ☐ Phlebitis ☐ Stroke/CVA ☐ Pacemaker	☐ Rash ☐ Sensitive ☐ Eczema ☐ Bruise easily ☐ Varicose veins ☐ psoriasis
Head/Neck	**Women**	**Men**	**Communicable**
☐ Ear problems ☐ Vertigo ☐ Blurred vision ☐ Vision loss ☐ Sinus issues	☐ Menstrual issues ☐ Menopause issues	☐ Prostate cancer ☐ Testicular cancer	☐ TB ☐ Hepatitis ☐ HIV
Other Conditions			
☐ Cancer ☐ Arthritis OA ☐ Arthritis RA ☐ Degenerative discs (where?)_____	☐ Epilepsy ☐ Hemophilia ☐ Diabetes – type_____	☐ Internal pins/wires (where?)_____ ☐ Artificial joints (where?)_____	
Muscle Pain and Tension			

Please indicate location **and** rate your pain:

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10

None mild severe



Consent

It is my choice to receive massage therapy/ acupuncture and it is my understanding that the information I have provided is confidential, except as required or allowed by law or to help facilitate treatment. You will be asked to provide written authorization for release of any information.

I agree to communicate with my massage therapist/ acupuncturist anytime I feel that my well-being is compromised, and I acknowledge that I may terminate the treatment at any point without reason.

I am aware that it is not necessary to remove all articles of clothing for treatment, and will remove the clothing I am comfortable with.

I am aware that I may experience possible side effects from the massage/ acupuncture treatments such as temporary muscle discomfort (24-48 hours post-treatment), bruising, headache, or dizziness.

I understand that payment is expected as service is rendered unless prior financial arrangements have been made.

I understand that any appointment that is cancelled without adequate notice (12-24 prior) will be subject to a missed appointment charge.

Signature Date