

Confidential Case History

Name: _____ Email: _____

Phone: (H) _____ (O) _____ (C) _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ M/F: _____ Marital Status: _____ # of Children: _____

Height: _____ Weight: _____ Referred by: _____

Employer: _____ Occupation: _____

Have you ever had a massage before? _____ If so, when and where: _____

What is your major area of pain or concern? _____

What is your goal for today's session? _____

Check any areas of difficulty occurring within the last six months:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> heart attack | <input type="checkbox"/> back pain | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> inflammation in throat | <input type="checkbox"/> chest pains | <input type="checkbox"/> arthritis | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> osteoporosis | <input type="checkbox"/> cancer | <input type="checkbox"/> chemical/fragrance sensitivity | <input type="checkbox"/> bladder trouble |
| <input type="checkbox"/> gall bladder trouble | <input type="checkbox"/> colitis | <input type="checkbox"/> glasses or contacts wearer | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> kidney trouble | <input type="checkbox"/> diabetes | <input type="checkbox"/> phlebitis | <input type="checkbox"/> swollen joints |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> pleurisy | <input type="checkbox"/> heart palpitation | <input type="checkbox"/> fibromyalgia |
| <input type="checkbox"/> scoliosis | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> headaches |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> pinched nerves | <input type="checkbox"/> skin irritations | |
| <input type="checkbox"/> thyroid | <input type="checkbox"/> TMJ dysfunction | <input type="checkbox"/> painful urination | |

Are you currently undergoing treatment for any health condition? Y / N If yes, please explain: _____

Current medications _____

Allergies to medications? _____ To foods? _____

Are you pregnant? Y / N

Habits	Heavy	Moderate	Light	None	List any: Past surgeries _____
Alcohol	_____	_____	_____	_____	_____
Coffee	_____	_____	_____	_____	Major car accidents _____
Tea	_____	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____	Broken bones _____
Exercise	_____	_____	_____	_____	_____
Sugar	_____	_____	_____	_____	
Water	_____	_____	_____	_____	

Please list any other health information you would like us to know on the back of this form...

This is a student massage clinic. We offer Swedish massage for relaxation and stress relief, which neither treats nor diagnoses disease and is not to be substituted for medical treatment. Students who are farther along in the program will be able to incorporate Sports massage and Neuromuscular Therapy techniques in their sessions. Periodically, during the course of massage, the clinic supervisor will be quietly observing. After completion of our massage, the supervisor will take a few minutes to get your feedback. If you are in pain, please seek the help of a certified therapist. As a student clinic client, you are responsible for your own well being and are aware that the students and/or ASHA accept no liability.

FULL CHARGE WILL BE MADE TO THE CREDIT CARD ON FILE FOR APPOINTMENTS CANCELED WITHOUT 24 HOURS NOTICE.

Signature _____ Date _____