INTERGRATIVE THERAPEUTIC MASSAGE

CLIENT CASE HISTORY

Name:_____ Date: _____

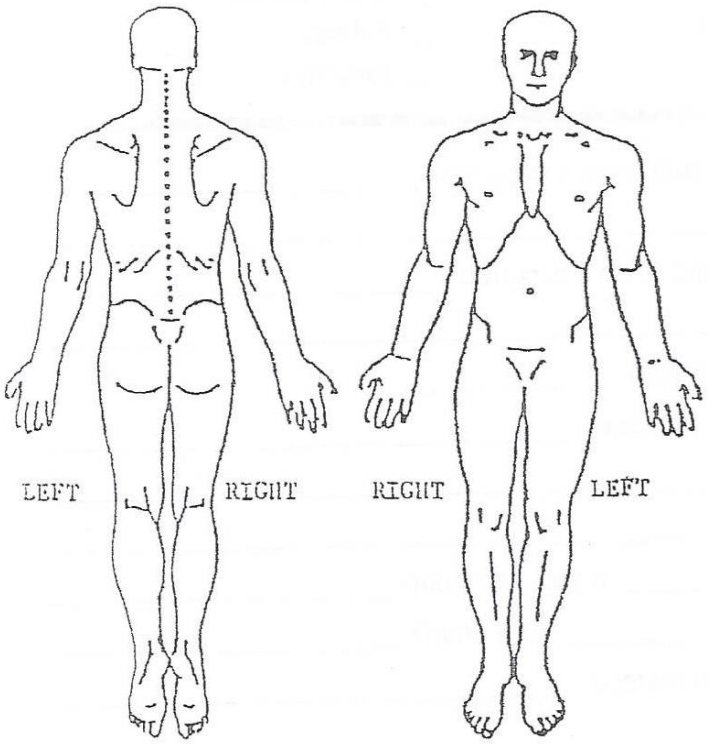
Address:_____ Phone: _____

_____ Email: _____

Date of birth: _____ Height _____ Weight _____ M ____ F ____

Occupation: _____ Primary Physician _____

If you are in pain or discomfort please mark the exact location on the diagram.
If the pain is shooting, indicate the direction.



Major Complaints

Please describe the type of pain you have. (i.e. dull, sharp, shooting, pins and needles, aching, throbbing, etc.)

_____
_____
_____
_____
_____

What activities cause or aggravate it? (i.e. standing, sitting, lifting, bending, sleeping, driving, computer work, etc.)

_____
_____
_____
_____
_____

What caused this condition?

_____

_____

When did you first notice this?

_____ Is it progressively getting worse? Yes _____ No _____ Constant _____ Comes and Goes _____

Have you received treatment for this condition? If yes, when and with who, and what were your results?

_____

_____

Over Please →

Please check any symptoms or conditions that have occurred within the past five years.

Check twice any that you are currently experiencing.

___Headaches __ Migraines
___Vision Problems
___Dizziness
___TMJ Dysfunction
___Chest Pain
___Heart Problems
___High Blood Pressure:
Treated?_____
___Anemia
___Varicose Veins
___Phlebitis or Thrombosis
___Arteriosclerosis
___Sinusitis
___Asthma
___Emphysema
___Loss of Range of Motion
Where?_____
___Numbness/Tingling
Where?_____

___Goiter or Thyroid Problems
___Stiff Neck/Shoulders
___Back Pain:
Where:_____
___Disc Problems:
Where?_____
___Abdominal Pain
___Digestive Upset
___Diverticulitis
___Constipation/Diarrhea
___Ulcers:
Where?_____
___Overweight
___Hernia or Rupture
___Liver Disorder
___Kidney Disease
___Diabetes
___Hypoglycemia
___Depression

___Allergies:
Type:_____
___Joint Pain:
Where:_____
___Paralysis:
Where?_____
___Arthritis:
Where?_____
___Radiating Pain?
Where?_____
___Muscle Spasms:
Where?_____
___Foot Pain
___Contagious Disease
___Cancer
Type:_____
___Skin Disorder
___Fatigue
___Insomnia

Any surgeries? Please explain what kind of surgery and when it occurred: _____

_____

Any musculoskeletal injuries? Please explain type and when it occurred: _____

_____

Are you pregnant? _____ If yes, how far along are you? _____

Are you taking medication? Please list and describe purpose: _____

_____

Do you take dietary supplements? Please list: _____

Have you ever had a professional massage before _____ If so, what type? _____

Please describe your health goals related to massage therapy:_____

_____

_____

I understand that a 24-hour notice for a change or cancellation of appointment is necessary. Failure to do so will require a $25.00 fee for the lost appointment times.

I understand that the scope of massage therapy includes the reduction of stress, muscular spasm or pain, improved circulation, energy, and sense of well-being. It is not within the scope of massage therapy to diagnose disease or perform medically licensed procedures.

SIGNATURE: _____ Date:_____