Date of update: ☐

Confidential Case History
Massage Therapy/Shiatsu/Reflex/

Last Name	First Name	Address		
City	Postal Code	Today's date	Phone # (home)	Phone # (work)
Date of birth	Occupation	Email address		
How did you hear about us?	Do you have extended insurance for massage?	Do you have extended ins for shiatsu/reflex?		
Medical Doctor's name	Dr's Phone #	Dr's address:		
General Health Status:	Is this your 1st massage?	Is this a motor vehicle accident case?		

Reason for consulting the office:

☐ I have no symptoms and feel well. I am interested in strategies to help me continue to feel well or even better.

☐ I have a specific problem and require help with this problem only and would like to learn how to prevent it from returning.

Current Health Condition

What is your major complaint?				
When did it start?	Have you had a similar problem in the past?			
The condition is: constant occasional getting worse	The condition is interfering with: work sleep daily routine other			
Have you consulted others regarding the condition?	Have you had xrays taken?			
What makes your condition worse? better?				
Have you ever been in a car accident?	Please list surgeries and major illnesses			
List any medications used & why	Any other health complaints?			

Do you smoke?	I sleep on my: back side stomach Do you sleep well?
What exercise do you do?	Are you allergic to any nut oils (peanut) or any aromatherapy oils?
What kind of pressure do you like? very deep deep medium light not sure ☐ ☐ ☐ ☐ ☐	Are you pregnant? Due Date?
Would you like a silent treatment? (music on, but not much talking so that you can relax deeply)	

Have you ever suffered from any of the following:

Migraine headaches	Phlebitis	Chronic fatigue syndrome
High/low blood pressure	Varicose veins	Fibromyalgia
Heart disease	Stroke	Poor circulation
Diabetes: type:	Bruise easily	Pins, wires, artificial limb
Presence of infectious cond?	Sinusitis	Degenerative discs
Muscle cramps	Vertigo	**Muscle pain/tension:**
Asthma	Earaches	Please circle all that apply
AIDS /HIV	Hepatitis	**Neck:** right left front back
Cancer	Herpes	**Shldr:** right left front back
Menstrual problems	Epilepsy	**Arms:** right left front back
Tuberculosis (TB)	Emphysema	**Legs:** right left front back
Congestive heart failure	Myocardial infarction	**Back:** upper mid lower
Family history of arthritis: _____	Arthritis OA RA	Cardiovascular accident
Vision/hearing loss	Chronic cough	Pacemaker or similar device
Shortness of breath	Bronchitis	Loss of sensation

Do you experience any of the following: please circle
dizziness/fainting pain that wakes you up Fatigue Sudden weight loss
Allergic reactions: anaphylactic skin irritations

Has it been more than 6 months since your last treatment?	Favourite parts of massage? (ie; back, neck)

If it is necessary to cancel an appointment, please note that we do require 24 hours in order to avoid paying for the missed appointment. (emergencies and illness do not apply) By signing below, I do consent to receive treatment.

_____ _____
Signature Date

PLEASE FEEL FREE TO ADJUST THE DEPTH OF THE TREATMENT AT ANY TIME.