PROFESSIONAL

CHINESE MASSAGE

THERAPY

CASE HISTORY FORM

DATE _____

NAME _____ _____
LAST FIRST

ADDRESS _____ PHONE #S H _____
CITY _____ W _____
POSTAL CODE _____ C _____

AGE _____ DOB _____ OCCUPATION _____

HEALTH HISTORY

- ☐ HEADACHES
- ☐ STRESS
- ☐ HIGH BLOOD PRESSURE
- ☐ PLANTAR WARTS
- ☐ FATIGUE
- ☐ SMOKER
- ☐ CANCER
- ☐ CONTAGIOUS CONDITION
- ☐ OTHER - PLEASE EXPLAIN

- ☐ MUSCLE PAIN
- ☐ LOW BLOOD PRESSURE
- ☐ DIFFICULTY SLEEPING
- ☐ BRUISE EASY
- ☐ DEPRESSION
- ☐ ALLERGIES
- ☐ POOR CIRCULATION
- ☐ HEART DISEASE

- ☐ JOINT PAIN
- ☐ ARTHRITIS
- ☐ DIABETES
- ☐ DISABILITIES

_____

☐ YES ☐ NO MOTOR VEHICLE ACCIDENT

DATE OF ACCIDENT _____

PLEASE DESCRIBE _____

SURGERY _____

CURRENT MEDICATIONS _____

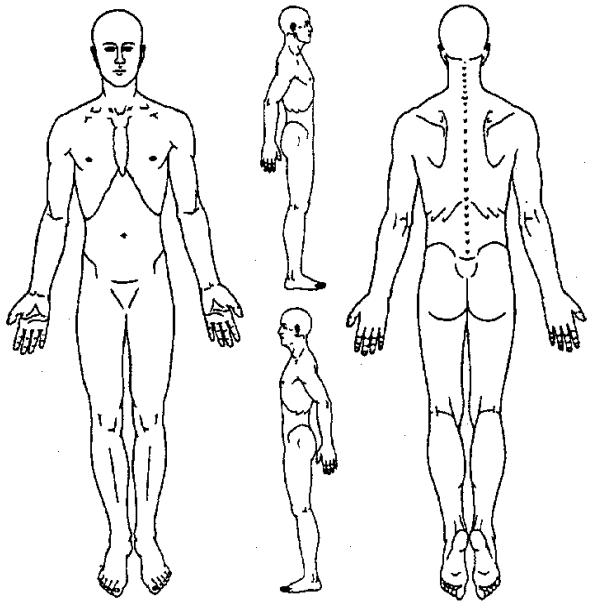
CHIROPRACTOR _____

PHYSIOTHERAPIST _____

PHYSICIAN _____

PCMT

PLEASE INDICATE ON THE CHART WHERE YOU FEEL YOUR AREA OF PAIN ARE:



THERAPIST NOTES (DO NOT WRITE IN THIS SPACE)

PLEASE DESCRIBE YOUR PAIN (IS IT SHARP? DO YOU HAVE SPASMS? ARE YOU EXPERIENCING BURNING, THROBBING PAIN, CHRONIC PAIN, DULL PAIN, ACHING PAIN, ETCETERAS?

WHEN DID YOU FIRST NOTICE YOUR PAIN?

WHEN DO YOU FEEL PAIN THE MOST (MORNING, EVENING, AFTER WORK, AFTER A CERTAIN ACTIVITY)?

ARE THERE ANY ALLEVIATING FACTORS (REST, HEAT, ICE, STRETCHING, ETECERTAS)?

I, _____ hereby release the massage therapist from any and all liability due to problems arising from the therapy as a result of the information not given or incorrectly given or change during the treatment period. The time allotted for your treatment includes an interview, assessment of your condition and a massage. If you have any questions or concerns please do not hesitate to ask.

SIGNATURE _____