**Confidential Case History** **Date:** _____

Name: _____ Date of Birth: _____
Address: _____ Tel (HM): _____
_____ Tel (WK): _____
Postal Code: _____ Tel (Cell): _____
Occupation: _____ Weight: _____ Height: _____
Doctor: _____ Dr. Tel #: _____
Address: _____
How did you hear of us? MD ☐ Newspaper ☐ Yellow Pages ☐ Friend ☐ Other ☐
Have you had massage in the past? ☐ Yes ☐ No
Are you currently seeing MD ☐ Chiropractor ☐ Physiotherapist ☐
Psychotherapist/Counselor ☐

**Health History:** Please check applicable boxes

Head/Neck:
☐ headaches – frequency _____
type: _____
☐ vision problems/loss
☐ contact lenses
☐ hearing loss/impairment
☐ fainting
☐ epilepsy
☐ sinus
☐ dizziness
☐ whiplash
date: _____

Respiratory:
☐ chronic cough
☐ shortness of breath
☐ asthma
☐ bronchitis
☐ emphysema

Women:
☐ pregnant
number of children _____
☐ menopause
☐ gynecological conditions

Cardiovascular:
☐ low blood pressure
☐ high blood pressure
☐ poor circulation
☐ heart disease
☐ hypoglycemia
☐ hardening arteries
☐ stroke
☐ hemophilia
☐ varicose veins
☐ chronic congestive heart failure
☐ pacemaker
☐ history of heart attack

Skin conditions :
☐ sensitive skin
☐ rashes/eruptions
☐ phlebitis
☐ bruise easily
☐ loss of sensation. where?
☐ infectious skin conditions

Digestive/Uro-genital:
☐ poor appetite
☐ constipation
☐ liver/gall bladder
☐ kidney/bladder
☐ difficult digestion
☐ diabetes
☐ ulcers

What is your general health status?

Other:
☐ arthritis ☐ osteoarthritis ☐ rheumatoid arthritis ☐ osteoporosis
☐ insomnia ☐ scoliosis ☐ fibromyalgia
☐ allergies (where response = anaphylaxis/skin irritation) – please list: _____
_____
☐ cancer – type: _____
☐ Other diagnosed diseases/medical conditions_____
☐ surgeries/accidents – type: _____date: _____
_____ date: _____
_____ date: _____
☐ Pins, wires, plates or artificial joints? _____ Where? _____

Current Medications:

Name: _____ Condition treated: _____
_____ _____
_____ _____
_____ _____