

# MASSAGE CONFIDENTIAL CASE HISTORY

NAME (LAST, FIRST, MIDDLE)		DATE
ADDRESS		CITY, STATE, ZIP
HOME PHONE	CELL PHONE	
E-MAIL	DATE OF BIRTH/AGE	SEX
OCCUPATION	EMPLOYED BY/WORK PHONE	
PHYSICIAN	REFERRED BY	

CONTACT IN CASE OF EMERGENCY/PHONE \_\_\_\_\_

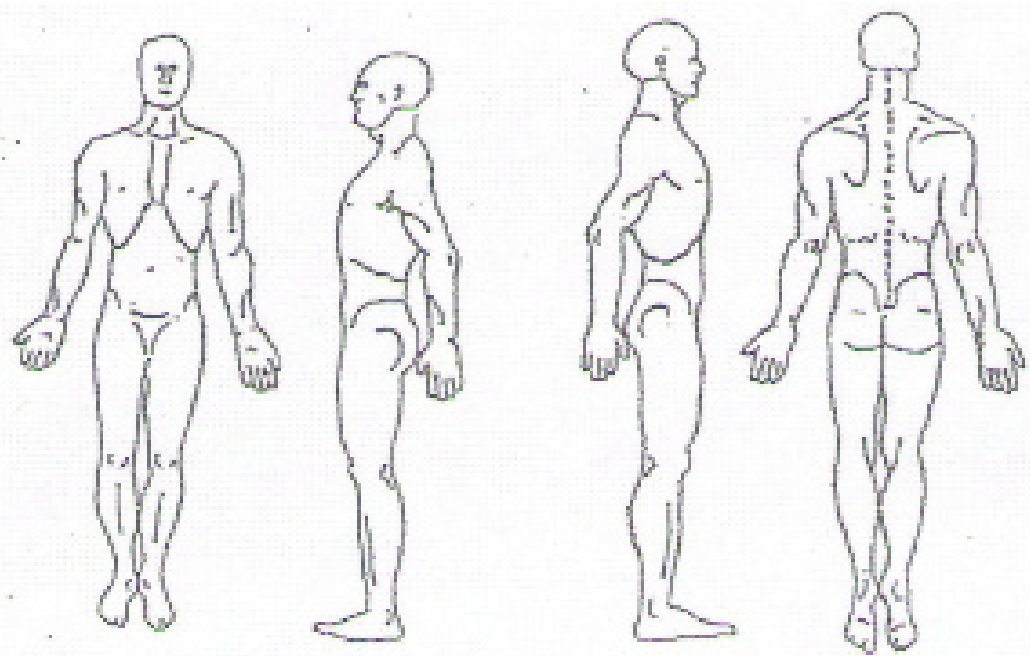
HAVE YOU HAD PROFESSIONAL MASSAGE BEFORE? YES \_\_\_\_\_ NO \_\_\_\_\_

PRIMARY REASON FOR VISIT: RELAXATION \_\_\_\_\_ MEDICAL \_\_\_\_\_ OTHER \_\_\_\_\_

PLEASE CIRCLE ANSWERS TO THE FOLLOWING QUESTIONS

- | PLEASE CIRCLE ANSWERS TO THE FOLLOWING QUESTIONS                   | PLEASE EXPLAIN "YES" ANSWERS |
|--|------------------------------|
| 1. Are you on any medication (including OTC, aspirin, supplements) | No Yes _____                 |
| 2. Are you currently seeing a doctor for any reason?               | No Yes _____                 |
| 3. Do you have any allergies?                                      | No Yes _____                 |
| 4. Do you have any medical condition(s) we should be aware of?     | No Yes _____                 |
| 5. Have you suffered any injuries lately?                          | No Yes _____                 |
| 6. Have you ever had surgery?                                      | No Yes _____                 |
| 7. Are you pregnant or trying to conceive?                         | No Yes _____                 |
| 8. Do you exercise regularly or participate in sports?             | No Yes _____                 |
| 9. Do you have any sites of pain or tenderness?                    | No Yes _____                 |
| 10. Do you have any numbness, swelling, fever, or infection?       | No Yes _____                 |
| 11. Are you sensitive to perfumes, lotions, or oils?               | No Yes _____                 |
| 12. Do you wear contact lenses?                                    | No Yes _____                 |
| 13. Do you wear dentures?  | No Yes _____                 |

PLEASE INDICATE AREAS OF TENSION OR DISCOMFORT ON THE BODY FORMS BELOW



**PLEASE SEE  
REVERSE  
SIDE.**

**CIRCLE ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING.**

**UNDERLINE ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST.**

Allergies	Edema	Osteoporosis
Anemia	Endometriosis	Parasites
Arteriosclerosis/atherosclerosis	Epilepsy/seizures	Parkinson's Disease
Arthritis	Fibromyalgia	Postural deviations
Asthma/emphysema	Gallbladder trouble	Pregnancy
Bladder/kidney trouble	Gout	Ringing in ears
Blood clots/phlebitis	H. pylori	Sciatica
Blood disorders	Headaches	Scoliosis
Breast tenderness, pain, or congestion	Heart problems	Sinus trouble
Bursitis	Hemophilia	Skin conditions (rash, ringworm, warts, etc.)
Cancer/tumors	Hepatitis	Sleep Apnea
Carpal tunnel	Herniated/bulging disk	Strain/Sprain
Chrohn's disease	High/low blood pressure	Tendonitis
Chronic Fatigue Syndrome	Hypo/hyperglycemia	Thyroid trouble
Constipation	Indigestion	TMJ
Contagious diseases	Inflammation	Tuberculosis
Depression	Insomnia	Varicose veins
Diabetes	Multiple Sclerosis	Warts
Dizziness	Muscle spasms	Whiplash
	Numbness	Other _____

I, \_\_\_\_\_, understand massage therapy and its modalities are for the purpose of stress reduction, relief from muscular tension or spasm, or increasing circulation and energy flow.

I understand the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. Massage therapy is not a substitute for medical examinations and/or diagnosis and it is recommended I see a physician for any physical ailments I may have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. Isthmus Acupuncture Center's policy states clients must always be professionally draped during the entire session.

I further acknowledge I may be refused treatment based on medical history or on the grounds of personal cleanliness. I understand a \$37.50 cancellation fee may be charged if the appointment is cancelled with less than 24 hours notice, or if I don't show up for the session.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**ISTHMUS ACUPUNCTURE CENTER, LLC**  
CHINESE HERBAL MEDICINE AND MASSAGE

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