# Wholesome Wellness
## Massage Therapy Intake
## www.wholesomewell.com
## (403) 615-8275

## CONFIDENTIAL CLIENT CASE HISTORY

## PERSONAL DATA

Name: _____ Date of birth (dd/mo/yyyy)_____
Address: _____ City, Province: _____
Postal Code: _____ Home Phone: _____ Cell Phone: _____
Email: _____
Occupation:_____ Referred By:_____

Emergency Contact: _____
Relationship: _____ Phone: _____

Have you used other complementary therapies in the past (i.e. acupressure, acupuncture, etc...)? Please list:
_____
_____

## CLINICAL DATA

Gender: _____ Height: _____ Weight: _____
Present injury/problem: _____
Started when? _____
What action aggravates/recreates the pain? _____
What eases the pain? _____
Does pain radiate (felt away from source)? _Y / N_ where?_____
Any stiffness/pain as result: _____
Past injuries/accidents/surgeries?_____
When? _____
Comments/details:_____
_____

## HEALTH HISTORY

*Circle all that apply* (mark **'P**' for **past** or '**C**' for **current** beside any that apply):

| | | | | |
|---|---|---|---|---|
| Asthma | Arthritis | Allergies (indicate:_____) | Blood clots | Bone injuries/ disease |
| Cancer/Tumors | Contact Lenses | Chronic Fatigue | Circulatory Problems | Depression |
| Dentures | Digestive Problems | Diabetes | Epilepsy | Fibromyalgia |
| Fracture | Hearing problems | Headaches / Migraines | Heart Attack | Heart Disease |
| Hernia | High Blood Pressure | Infectious Disease | Low Blood Pressure | Motor Vehicle Acc. |
| Muscle / Joint Pain | Muscle / Joint Stiffness | Numbness / Tingling | Phlebitis | Paralysis |
| Pregnancy (women) | Rash /Athlete's Foot | Seizures | Skin Disorders | Stroke |
| Surgery | TMJ Disorder | Vision Problems | Varicose Veins | Other: _____ |

*Circle any that you experience **once or twice per week***:

| | | | | |
|---|---|---|---|---|
| Alcohol (# per day __) | Allergies | Cold hands and feet | Constipation | Caffeine (#per day__) |
| Excessive urination | Fainting/Dizziness | Fatigue | Grinding of teeth | Headache |
| Heart or chest pain | Heavy limbs | Indigestion | Insomnia | Lower back pain |
| Loose bowel movements | Nervousness | Poor appetite | Smoking (#per day__) | Sore muscles |
| Tightness of jaw | Weakness | Other: _____ | | |

Comments/details:_____

# Wholesome Wellness
## Massage Therapy Intake
## www.wholesomewell.com
## (403) 615-8275

## MEDICATIONS / VITAMINS / SUPPLEMENTS / HERBS

| Name: | Dosage/day: | Reasons for taking: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

On the image below please indicate, according to the legend, areas where you experience pain, numbness or tightness and areas where you may be ticklish.

**Legend**

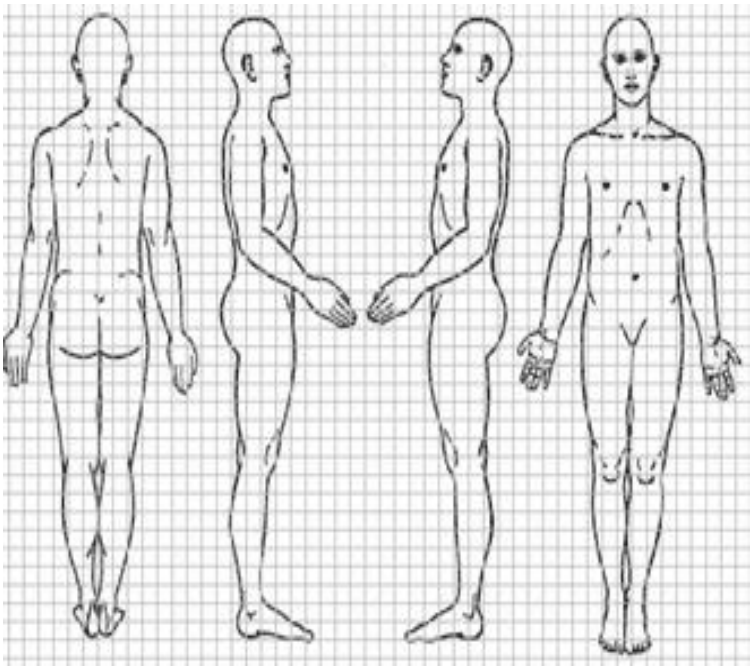
| | | |
|---|---|---|
| *** | = | pain |
| NNN | = | numbness |
| XXX | = | tightness |
| TTT | = | ticklish |

How would you describe the pain:

_____

For areas of pain please indicate your pain level on a scale from one to ten (ten being the worst):

| Area of pain: | Patient Pain Scale: |
|---|---|
| _____ | _____ out of 10 |
| _____ | _____ out of 10 |
| _____ | _____ out of 10 |



Waiver and Consent Form:

I,_____(type name), release the massage practitioner from any and all liability from problems arising from the treatment as a result of information not given, or incorrectly given in this patient history.

I further understand that the massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for physical or mental ailment that I am aware of.

Because massage is contraindicated under certain conditions, I affirm that I have stated my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand there is no liability on the therapist's part should I forget to do so.

Because my personal and medical information is confidential, I understand that this information will be seen only by the therapist, unless I give my consent in writing.

Client Signature**:** _____ Date**:** _____