Riverbend Massage Therapy
Confidential Case History

Please fill out the following information as completely as possible in order to assist your Registered Massage Therapist in providing the best possible care.

PERSONAL HISTORY

Name: _____ Address: _____ Postal Code: _____

Phone: H _____ W _____ C _____

Date of Birth (M/D/Y) _____ Gender: M F Height: _____ Weight: _____

Primary Health Provider: _____ Occupation: _____

Who referred you? _____ Private Health Insurance Company Name: _____

Primary Plan Holder's Name: _____ Policy # _____ Group # _____

Email Address: _____

HEALTH HISTORY

Is this massage for: Therapeutic ☐ Relaxation ☐

What is your present complaint? _____

_____

Do you know the reason for your problem? _____

_____

Has there been any previous treatment? _____

_____

What makes the problem better/worse? _____

_____

Are you taking medications? _____

_____

Any previous operations? _____

Any previous auto accidents?_____

Please check any of the following conditions that are currently affecting you or have been a problem in the past.

MUSCULOSKELETAL

☐ Tendinitis ☐ Sprain/strain ☐ Bursitis ☐ Bone fractures ☐ Back pain
☐ Leg/hip pain ☐ Neck pain ☐ Shoulder/arm pain ☐ Jaw pain
☐ Headache ☐ Osteoarthritis ☐ Osteoporosis

CIRCULATORY

☐ High blood pressure ☐ Heart disease ☐ Varicose veins ☐ Blood clots ☐ Swelling
☐ Low blood pressure

RESPIRATORY

☐ Asthma ☐ Bronchitis ☐ Allergies ☐ Emphysema ☐ Breathing difficulty

SKIN

☐ Rashes ☐ Allergies ☐ Fungal (athlete's foot) ☐ Warts

DIGESTIVE

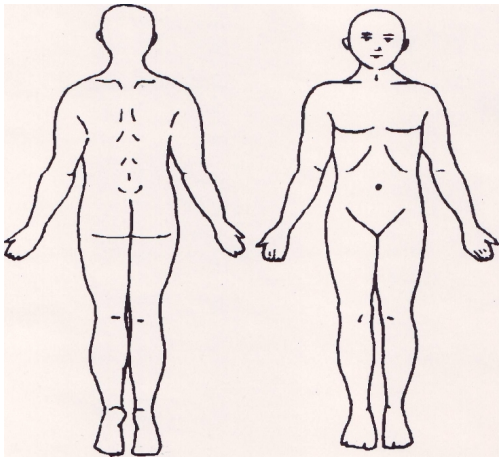
☐ Constipation ☐ Gas/bloating ☐ Inflammatory bowel disease ☐ Other

NERVOUS SYSTEM

☐ Numbness/tingling ☐ Chronic pain ☐ Shingles ☐ Fatigue ☐ Depression ☐ Other

OTHER HEALTH CONCERNS

☐ Cancer ☐ Diabetes ☐ Stroke ☐ Thyroid ☐ Organic disease



Please outline on the diagram the area of your discomfort.

I agree to the treatment approach recommended by Riverbend Massage Therapy. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes that may occur in my health status. I release the Massage Therapist any and all liability as a result of information not give or incorrectly given in the Case History.

I am also aware that there is a charge of $31.50 for missed appointments without 24 hours notice.

Patient Signature_____ Date_____