Truhealth
& wellness
Achieve and maintain a higher personal best.

Case History

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: ____ **Date:** ______________________

Address: ____ **City:** ______________________________

Postal Code: _________________ **Cell Phone:** ______________________ **Text Msg: YES / NO**

Home phone: ________________ **Work Phone:** ____________________ **E-mail:** ________________________

Date of Birth: ________________ **Health Benefits: YES / NO**

Occupation: _______________________ **Where:** _______________**Do you: Sit / Stand / Other**_____________

Recreational Activities: ____

Family Physician: _______________________________**Phone Number:**_________________________________

Emergency contact: _____________________________ **Phone Number:** _______________________________

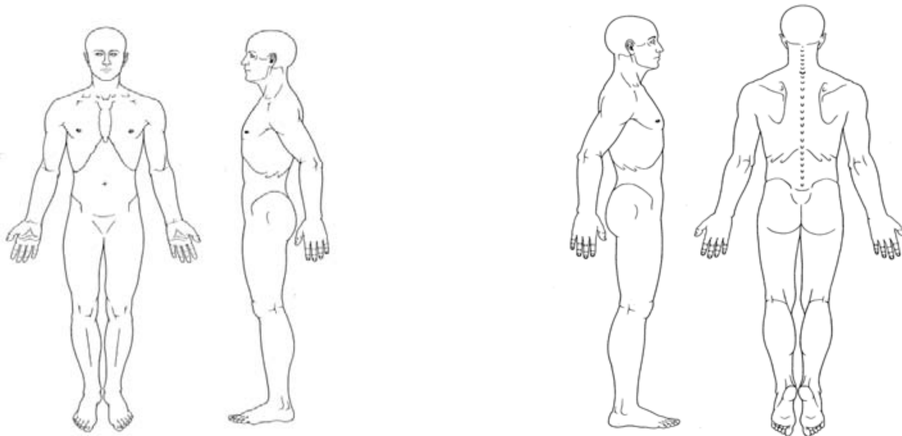
Where did you first hear about the clinic? ____

What brings you in for a massage? **Relaxation / Stress / Injury / Pain / Rehabilitation / Education**

What is your primary complaint? _______________________ **How Long:** ___________________________

What have you tried for relief? ☐ **Heat** ☐ **Cold** ☐ **Exercise** ☐ **Other:** _______________________

Locate the areas of pain and discomfort on the following chart.



Health History

☐ **Please check all that are relevant.**

Yearly Revisions

	Initial
2017	______
2018	______
2019	______
2020	______
2021	______
2022	______
2023	______

Head/Neck

- Vision problems ☐
- Vision loss ☐
- Ear problems ☐
- Hearing loss ☐
- Headaches ☐

Cardiovascular

- High Blood Pressure ☐
- Low Blood Pressure ☐
- Heart Condition / Disease ☐
- Diabetes (onset______) ☐
- Varicose Veins ☐
- Stroke / CVA ☐
- Dizziness ☐
- Phlebitis ☐
- Chronic Myocardial Infarction ☐
- Pacemaker ☐

Muscles/Joints

- Stiffness ☐
- Weakness ☐
- Arthritis ☐
- Upper Back ☐
- Mid Back ☐
- Lower Back ☐
- Shoulder ☐
- Knee ☐
- Arm ☐
- Neck ☐
- Feet ☐
- Hands ☐
- Osteoporosis ☐
- Swelling ☐
- TMJ ☐
- Ankle ☐

Surgeries

Type: ________________________
Date: __________________
Current Symptoms: ____________
____
____

Digestion/Elimination

- Constipation / Diarrhea ☐
- Liver / Gallbladder ☐
- Kidney / Bladder ☐
- Diverticulitis ☐
- Ulcers ☐
- Hypoglycemia ☐
- Nausea/Gas ☐
- Celiac ☐

Nervous System

- Nervous Depressed ☐
- Fatigue ☐
- Insomnia ☐
- Psychosis ☐
- Sciatica ☐
- Epilepsy ☐
- Loss of sensation ☐

Immune System

- Allergies/Sinus ☐
- Cancer ☐
- Aids / HIV ☐
- Hepatitis ☐
- Anaphylactic reaction ☐
- T.B ☐

Respiratory

- Chronic Cough ☐
- Shortness of Breath ☐
- Asthma ☐
- Emphysema ☐
- Bronchitis ☐

Current Medications/Supplements

Condition it treats: _____________
____
____
____

Skin

- Sensitive ☐
- Rashes / Eruptions ☐
- Contagious Condition ☐

For Women

- PMS ☐
- Pregnant (due_____) ☐
- Menopause ☐

Of Special Note:

Presence of:

- Internal pins/wires ☐
- Artificial joint ☐
- Special equipment ☐

Other Health Care

- Previous Massage ☐
- Chiropractic ☐
- Physiotherapy ☐

Other: ________________________
____
____

	Y	N
Good Sleeping Habits	☐	☐
Regular Exercise	☐	☐
Regular Eating Habits	☐	☐
Stressed	☐	☐
Smoke	☐	☐

Injuries

Type: __________________________
Date: ______________
Current Symptoms: ____________
____
____

I have answered the above to the best of my knowledge, and all information is current and accurate.

Signature: ___________________________

Massage Therapist notes: