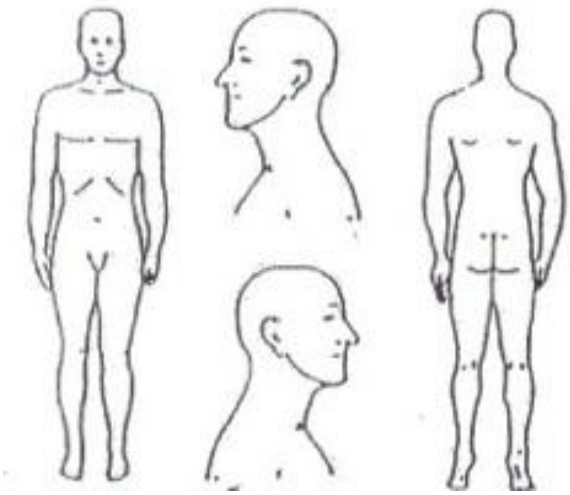
Stouffville Therapeutic Centre
For Massage, Shiatsu & Reflexology

CASE HISTORY

Today's date _____ Date of Birth _____
Name _____ Height _____ Weight _____
Street Address _____ Referral _____
City, Province _____ (MD, sign, ad, friend – name, website, etc.
Postal Code _____ Doctor _____
Phone No. Home ( ) _____ Address _____
Work ( ) _____ _____
Cell ( )_____ Phone No. ( )_____
E-mail (optional) _____
Occupation _____

Previous Massage Experience: ☐Yes ☐ No Reason for Massage _____

Indicate areas of discomfort on the diagram.



Current Symptoms _____
_____
_____
How long have you had this? _____
My muscle or joint discomfort is:
___ sharp ___ dull ___ achy ___ throbbing
___ burning ___ pins & needles
Frequency of symptoms
___ comes & goes ___ often ___ constant
What increases the discomfort _____
_____
What decreases the discomfort _____
_____
Scale of intensity of the discomfort:
1 2 3 4 5 6 7 8 9 10
mild moderate severe
Overall how is your general health? _____
_____

Indicate any pins, wires, plates, prosthesis, pacemaker or hearing aids, canes, walkers, medic alert bracelet, etc.
_____

Have you had any injuries, fractures, car accidents, surgeries, etc. (What? When? Current Symptoms?)_____
_____

Signature _____ Date_____

Stouffville Therapeutic Centre CASE HISTORY
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Name _____ **Fill in first column of each section.**

	Year		
HEAD/NECK			
TMJ/Jaw Problems			
History of Headaches			
Tension/Migraine			
Vision Problems/Loss			
Hearing Problems/Loss			
Sinus			
RESPIRATORY			
Chronic Cough			
Shortness of Breath			
Bronchitis			
Asthma			
Emphysema			
Family History of above (circle)			
CARDIOVASCULAR			
High Blood Pressure			
Low Blood Pressure			
Heart Disease			
Stroke (CVA)			
Atherosclerosis			
Phlebitis/Varicose Veins			
Haemophilia			
Reynaud's			
Poor Circulation			
Chronic Congestive Heart Failure/CCHF			
Heart Attack/Angina			
Family History of above (circle)			
SKIN			
Poor Healing			
Loss of Sensation Where? _____			
Skin Conditions Where? _____			
Bruises easily			
ALLERGIES/HYPERSENSITIVITY			
What kind/Type of Response? _____ _____			
Any Anaphylactic?			

	Year		
BODY PAIN AREAS			
Neck			
Shoulder - left/right			
Arm - left/right			
Upper Back			
Mid Back			
Low Back			
Leg - left/right			
Knee - left/right			
Swelling/where? _____			
Arthritis/where? _____			
Family history of arthritis			
LIFE STYLE ACTIONS			
Smoking			
Water ____oz./day			
Meditation/Relaxation			
Regular Exercise			
OTHER MEDICAL CARE			
Last Physician Visit _____			
Chiropractic			
Physiotherapy			
Psychotherapy			
Other _____			
MEDICATIONS			
Laxative			
Anti-inflammatory			
Pain Killing			
Sleeping Pill			
Vitamins			
Herbal			
Blood Pressure			
Heart			
Attach a list of meds available			

	Year		
OTHER ISSUES			
Difficult Digestion			
Constipation/Diarrhea			
Liver/Gall Bladder			
Diabetes – Onset? _____			
Hypo/Hyperglycemia			
Insomnia			
Fibromyalgia			
Hernia			
Urinary Disorders			
Epilepsy			
Hypothyroidism			
Hyperthyroidism			
Mental Illness			
Cancer/Where/When? _____			
INFECTIONS			
Herpes/Cold Sores			
Hepatitis			
Plantar warts			
TB			
HIV/AIDS			
Meningitis			
STD			
WOMEN			
Menstrual Problems			
Gynaecological Conditions/What? _____ _____			
Caesarean Section			
Pregnant			
Due Date			
Children-Number ___			

YOUR SESSION IS IMPORTANT. PLEASE GIVE 24 HR. NOTICE OF CANCELLATION.