

# TOTAL HEALTH SYSTEMS

## Multi-Specialty Clinic

Chiropractic • Medical • Physical Therapy • Massage Therapy • Nutrition

### Massage Therapy—Confidential Case History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Sex  M  F (ARE YOU PREGNANT? YES NO)

Phone: home( ) \_\_\_\_\_ work( ) \_\_\_\_\_ email \_\_\_\_\_

Reason for seeking a massage?  Stress reduction  Experience  Relaxation  Other \_\_\_\_\_

How did you first hear about us? \_\_\_\_\_ Have you had a professional massage before? YES NO

Is this your first visit to our office? Yes No Have you utilized any of our other services? YES NO

Briefly explain your current problem \_\_\_\_\_

When did you first notice it? \_\_\_\_\_

Does your problem interfere with your  Job?  Sleep?  Daily routine?

What activities aggravate the condition? \_\_\_\_\_

What helps the condition? \_\_\_\_\_

Is it getting  Worse?  Better? Is it  constant?  Comes and goes?

Are you taking any medication or having any special treatments at this time? \_\_\_\_\_

Previous injuries or surgery? \_\_\_\_\_

Please check **ALL THAT APPLY**:

- |                                                  |                                           |                                             |                                                  |                                                            |
|--------------------------------------------------|-------------------------------------------|---------------------------------------------|--------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness     | <input type="checkbox"/> Headache         | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Diarrhea/Constipation             |
| <input type="checkbox"/> Low Back Pain/Stiffness | <input type="checkbox"/> Muscle Tightness | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Degenerative/Rheumatoid Arthritis |
| <input type="checkbox"/> Shoulder/Arm Pain       | <input type="checkbox"/> Jaw Problems     | <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Artery/Vein Problems    | <input type="checkbox"/> Bacterial/Viral Infection         |
| <input type="checkbox"/> Hip/Leg Pain            | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Diabetes (I or II)                |
| <input type="checkbox"/> Numbness/Tingling       | <input type="checkbox"/> Sinus Problems   | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Skin allergies          | <input type="checkbox"/> Cancer                            |
| <input type="checkbox"/> Trauma/Injury/ Whiplash | <input type="checkbox"/> Wear Contacts?   | <input type="checkbox"/> Thyroid Problems   | <input type="checkbox"/> Other Allergies         | <input type="checkbox"/> Stroke                            |

Some of your symptoms listed above may be originating from abnormal spinal structure and function. Check **YES** to have a consultation with one of our *Board Certified Chiropractic Physicians*

**Yes**, I would like the complimentary consultation following my massage.  **No**, I waive my right to have a consultation.

I hereby consent to bodywork with the understanding that massage therapy is given for the purpose of stress reduction, relief from muscular tension, or for increasing circulation and energy flow. **\*\*For Detoxification Massage only: due to the strength of essential oils, there may be some irritation to those with sensitive skin.** I understand that the results of massage vary from individual to individual and that no specific results can be guaranteed. I understand that a massage therapist does not treat, prescribe for, or diagnose any illness, disease or any other physical or mental disorder, injury or condition. Nothing said or done by the massage therapist should be construed as such. I understand that a massage therapist must be aware of my physical conditions and have stated all my known medical conditions and will keep the massage therapist updated on my physical health. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the "full" scheduled appointment. **Cancellation Policy:** You will be charged for cancellations of less than 24 hours notice. We hope you understand this policy and respect the value of our time. Thank you.

Signature \_\_\_\_\_

Date \_\_\_\_\_

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[www.totalhealthsystems.com](http://www.totalhealthsystems.com)