The Retreat | massage & wellness centre

# Remedial Massage Confidential Case History Form

Please take a moment to fill out this confidential health history form.
This will ensure that you receive proper treatment and that it is safe for you to do so.
Please advise your practitioner if you are pregnant prior to filling in this form. Thankyou

Name:_____

Email:_____

Address:_____ Postal Code:_____

Phone: Mobile_____ Home_____ Date of Birth: _____/____/____

Occupation: Current:_____ Significant previous:_____

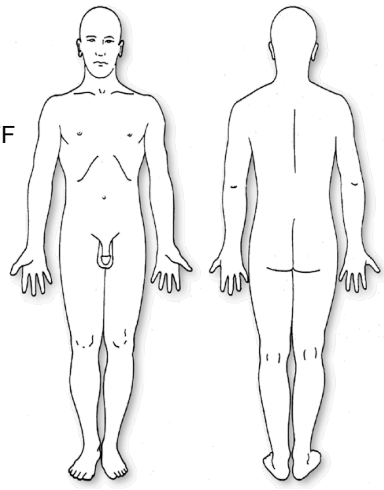
Recreational activities:_____ Right handed ☐ Left handed ☐

Health benefit fund:_____

Referred by / how did you hear about this clinic?_____

What is your primary complaint (reason for visit)_____

## *Please indicate discomfort areas on the chart



Can you describe your pain? DULL/ SHARP/ SHOOTING/ ACHY/ NUMB/ TINGLING/ STIFF

Pain scale: (low) 1--------5--------10 (high)

Does it radiate anywhere?_____

Does anything aggravate your symptoms?_____

Does anything relieve your symptoms?_____

When did your symptoms begin?_____

Have they changed & how _____

Is this condition interfering with: WORK / SLEEP / DAILY ROUTINE / ACTIVITIES

(please explain)_____

## Previous Treatments:

| | | |
|---|---|---|
| ☐ Acupunture | ☐ Massage | ☐ Podiatry |
| ☐ Chiropractic | ☐ Physiotherapy | ☐ Naturopathy |
| ☐ Osteopathy | ☐ GP | ☐ Reflexology |

## Car / Sporting / or accidental Traumas:

Experienced at any stage of life ☐ Yes ☐ No Years since incident _____

Did you experience whiplash? ☐ Yes ☐ No Did you receive any treatments? ☐ Yes ☐ No

Do you experience headaches? ☐ Yes ☐ No

If motor related, were you hit from the side or behind?

Do you have any internal pins/wires/artificial joints?_____

Surgery/injuries/hospitalization: (date, past & current symptoms)_____

_____

## Current medication:

Western:_____ Conditions used for:_____

Homeopathic and Herbal:_____ Conditions used for:_____

## Life style:

| | | | |
|---|---|---|---|
| Smoker: | Yes | No | Previously |
| Diet: | Poor | Average | Good |
| Hydration per day: | 2 Glasses | 5 Glasses | 8+ Glasses |
| Caffeine intake per day: | 1 serves | 3 serves | 5+ serves |

Do you have any difficulty lying down? On your front ☐ Yes On your back ☐ Yes

Do you sit for long periods of time at a workstation, Computer or driving? ☐ Yes ☐ No

Do you experience high levels of stress in your work, family or other aspects of your life? ☐ Yes ☐ No

If yes, does this affect your ☐ muscle tension ☐ anxiety ☐ insomnia ☐ mood swings ☐ other _____

Massage pressure preference: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Please circle a number: Very Gentle Relaxing Firm Deep Tissue Very Deep Tissue

**Please check all below that apply.**

| | | |
|---|---|---|
| **HEAD / NECK**<br><br>Headache<br>Migraine<br>Visual Disturbances<br>Contact lenses/glasses<br>Earaches<br>Hearing Problems<br>Jaw Pain / Dental Problems<br>Whiplash | **MUSCLE / JOINTS**<br><br>Neck<br>Low back<br>Mid back<br>Upper back<br>Shoulder<br>Hip<br>Knee<br>Ankle | **CARDIOVASCULAR**<br><br>High/ Low blood pressure<br>Chronic Congestive<br>Poor circulation<br>Haemophiliac<br>Stroke<br>Heart attack<br>Pacemaker<br>Heart disease (*please specify*) |
| **DIGESTIVE / URINARY**<br><br>Difficult Digestion<br>Constipation<br>Liver / Gallbladder<br>Kidney / Urinary<br>Diabetes (Type & Onset)<br>Hypoglycemia<br>Crohn's disease<br>Irritable bowel | **SKIN**<br><br>Bruise easily<br>Eczema Psoriasis<br>Varicose Veins<br>Skin condition<br>Plantar warts<br>Cold sores<br><br>**FEMALE**<br>Menstrual problems<br>Gynaecological conditions | **INFECTIOUS CONDITIONS**<br><br>Tuberculosis<br>AIDA / HIV<br>Hepatitis_ Type_____<br><br>**RESPIRATORY**<br>Asthma<br>Smoker<br>Emphysema<br>Bronchitis<br>Shortness of breath |
| **OTHER**<br><br>Cancer _ *Type*_____<br>Athlete's foot<br>Arthritis OA _ RA<br>Fibromyalgia<br>Osteoporosis<br>Chronic fatigue syndrome<br>Carpal tunnel syndrome<br>Fainting/dizziness<br>Scoliosis | Lack of motivation<br>Fatigue<br>High stress<br>Fear<br>Anorexia<br>Insomnia<br>Nervousness<br>Epilepsy | Mood swings<br>Worry<br>Low self esteem<br>Anger<br>Grief<br>Hormonal changes<br>Addictive personality<br>Anxiety |

*I acknowledge the above information as being true to the best of my knowledge and agree that all information is confidential.*

*Signature:*_____ *Date:*_____