CORE INSIGHT

Massage Therapy Confidential Medical History Form

Client Name:_____ Date:_____

Mailing Address:_____ Home Phone:_____

_____ DOB:_____

Occupation:_____ Work Phone:_____

Emergency
Contact:_____ Relationship:_____ Phone:_____

Physician Name:_____ Phone:_____
Date of last medical examination:_____

List any past Surgeries/Injuries and year occurred:_____

Do you have any surgical implants such as pins, metal plates, pacemaker, Harrington rods, other? Y/N If yes, where?_____

List any medications you are taking?_____

Are you undergoing any other form of treatment? Y/N
If yes, please give details_____

Have you ever been involved in a Motor Vehicle Accident? Y/N
If yes, please give details_____

Do you exercise regularly? Y/N

What is your primary complaint?_____

Have you seen a medical doctor for this condition? Y/N
If yes, what was the diagnosis?_____

Any other health problems your massage therapist should know about?

General Pain Disability Index Questionnaire

Name (Please Print):_____ Date:_____

Age:_____ Date of Birth:_____ Occupation:_____

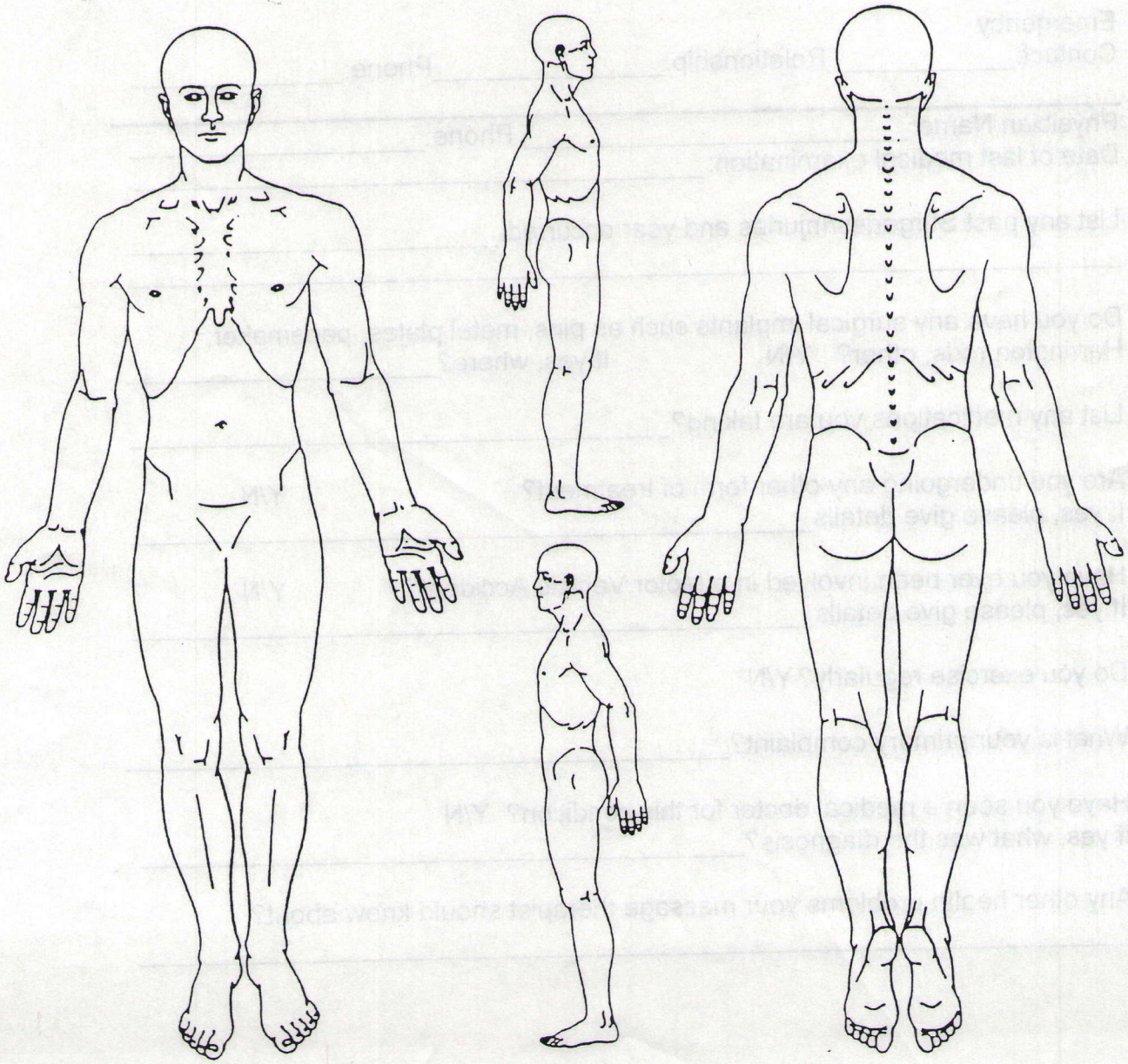
How long have you had this pain? ____YEARS ___MONTHS ____WEEKS

Is this your first episode of this pain? _____YES _____NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

Key:

A = ACHE	**B= BURNING**	**N=NUMBNESS**
P = PINS & NEEDLES	**S = STABBING**	**O=OTHER**



Please indicate any past of current health problems:

Musculo Skeletal
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Chronic Pain Syndrome
- ☐ Gout
- ☐ Swollen Joints
- ☐ Stiff Joints
- ☐ Hypermobility
- ☐ Hypomobility
- ☐ Pain
- ☐ Tension
- ☐ Spinal curvature
- ☐ Poor Posture
- ☐ Bursitis
- ☐ Tendonitis
- ☐ TMJ Dysfunction
- ☐ Fractures

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Smoking
- ☐ Cystic Fibrosis

Cardiovascular
- ☐ Stroke or CVA
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Varicose Veins
- ☐ Phlebitis
- ☐ Poor Circulation
- ☐ Arteriosclerosis
- ☐ Irregular Heart Beat
- ☐ Congestive Heart Failure
- ☐ Deep Vein Thrombosis
- ☐ Heart Disease
- ☐ Angina

Digestive/Genito-Urinary
- ☐ Constipation
- ☐ Diarrhea
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Irritable Bowel Syndrome
- ☐ Digestive Problems
- ☐ Bladder Infections
- ☐ Kidney Infections
- ☐ Liver / Gall bladder Problems
- ☐ Hernia
- ☐ Ulcers

Communicable Diseases
- ☐ Chicken Pox
- ☐ Measles
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Herpes

Neurological
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Sciatica
- ☐ Parkinson's
- ☐ Cerebral Palsy
- ☐ Spinal Cord Injury
- ☐ Meningitis
- ☐ Trigeminal Neuralgia
- ☐ Neuritis
- ☐ Neuralgia

Skin Conditions
- ☐ Psoriasis
- ☐ Eczema
- ☐ Acne
- ☐ Dryness
- ☐ Itching
- ☐ Sensitive Skin
- ☐ Shingles

Other
- ☐ Cancer
- ☐ Eye Problems
- ☐ Ear Problems
- ☐ Bruise Easily
- ☐ Altered Sensation
- ☐ Fainting/Dizziness
- ☐ Diabetes
- ☐ Allergies
- ☐ Undiagnosed Lump
- ☐ Leg Cramps
- ☐ Headaches/Migraines
- ☐ Slurred Speech
- ☐ Weakness, clumsiness or loss of strength
- ☐ Acute Inflammatory Conditions
- ☐ Alcohol or Drug Addictions
- ☐ Loss of consciencousness

For Women Only
- ☐ Endometriosis
- ☐ Menstrual Problems
- ☐ Backaches/Cramps
- ☐ Menopause
- ☐ Pregnant? If yes what trimester?_____

Authorization (please read carefully)

I hereby authorize my Physician and/or healthcare provider to provide from my records information concerning the state of my health, as requested by Core Insight, for the purpose of performing massage therapy treatment. All information provided on this form is accurate, to the best of my knowledge. I acknowledge that by cancelling my massage therapy appointment without 24 hours notice may result in a missed appointment fee. I understand that by signing below, I indicate my consent to massage therapy treatment.

Name: Signature: Date: