MEDICAL HISTORY
CONFIDENTIAL SHEET

Welcome to REVELATIONS ~ A Center for Wholeness! We intend to make your experience as pleasant and comfortable as possible.
If at any time you have questions regarding your therapy session, please let us know.

Date: _____

Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Employer: _____ Occupation: _____

Marital Status: □ M □ W □ D □ S Emergency Contact: _____

Who referred you to our office, or how did you hear about us?_____

Have you ever received massage therapy? □ Yes □ No

Type of Massage Experienced: □ Swedish □ Deep Tissue □ Other When was your last massage? _____

Have you ever received a Reiki treatment? □ Yes □ No When was your last treatment? _____

Are you currently under a Doctor's Care? □ Yes □ No Condition? _____

Doctor's Name & Contact Information: _____

Research is showing that many of our health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	Yes	No	Explanation
Do/did you have any diseases/disorders? (physical, mental, emotional)	□	□	_____
Do/did you have any falls from over 3 feet?	□	□	_____
Do/did you play sports?	□	□	_____
Do/did you take/use any drugs?	□	□	_____
Was there any prolonged use of medicine's (i.e. antibiotics, inhaler)?	□	□	_____
Were you involved in any car accidents or other types of collisions?	□	□	_____
Did you suffer any form of abuse (i.e. mental, emotional, physical)?	□	□	_____
Do/did you smoke?	□	□	_____
Do/did you drink alcohol?	□	□	_____
Do/did you suffer from any form of addiction?	□	□	_____
Are you currently taking medications (prescription and/or OTC)?	□	□	_____

Please list below *(name, purpose, & dosage):*

_____

_____

_____

Do you currently have or have you ever had (please explain):

- ☐ 1. Arthritis
- ☐ 2. Tendonitis/Bursitis
- ☐ 3. Conn. Tissue Disorders
- ☐ 4. Headaches
- ☐ 5. Dizziness
- ☐ 6. Neck pain/injury
- ☐ 7. Fatigue/Insomnia
- ☐ 8. Recurring respiratory problems (asthma, difficulty breathing, etc.)
- ☐ 9. Digestive problems (constipation, nausea, etc.)
- ☐ 10. Kidney trouble
- ☐ 11. Skin Disease
- ☐ 12. Cancer
- ☐ 13. Diabetes
- ☐ 14. Heart trouble (recent stroke, heart attack, etc.)
- ☐ 15. Blood Clots
- ☐ 16. Vericose Veins
- ☐ 17. High/low blood pressure
- ☐ 18. Nervous system disorder (neuritis, numbness/tingling, etc.)
- ☐ 19. Accidents
- ☐ 20. Broken bones/sprain.
- ☐ 21. Surgery
- ☐ 22. Bruise easily
- ☐ 23. Pregnant
- ☐ 24. Contacts
- ☐ 25. Back Pain/injury
- ☐ 26. HIV/AIDS
- ☐ 28. Not listed

If BACK PAIN/INJURY and/or NECK PAIN/INJURY is checked, please indicate on the chart below.

If you are experiencing a symptom, is it… *(check more than one if necessary to describe your problem)*

☐ Sharp ☐ Dull ☐ Burning ☐ Numbness & Tingling ☐ Pressure ☐ Comes & Goes ☐ Travels ☐ Constant

☐ Other; please explain: _____

Where is the symptom? _____

When did the *symptom* first start? _____

Since the symptom started, it is…

☐ About the same ☐ Getting Better ☐ Getting Worse

What makes it worse: _____

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

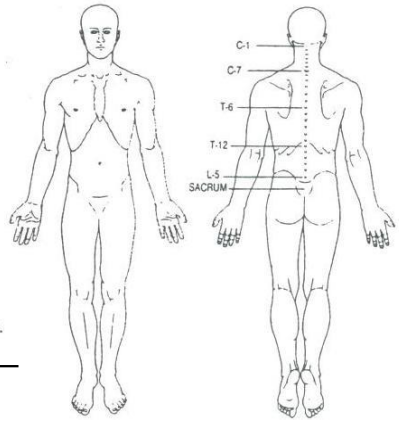
Does this cause you to be: ☐ Irritable ☐ Moody ☐ Worried

Other Doctors seen for this problem and when (please list):

☐ Chiropractor _____ ☐ Medical Doctor _____ ☐ Other _____

☐ Psychiatrist _____

PLEASE INDICATE WITH AN (X), THE AREAS YOU ARE FEELING DISCOMFORT



Past Surgeries / Operations: _____

Frequent body positions: stand ☐ kneel ☐ sit ☐ stoop ☐ bend ☐ driving ☐ lifting ☐

If HEADACHE is checked, what is the frequency_____ migraines? _____

Please list any trauma to the head_____

Where do you hold stress in your body? *List according to the area of highest stress first.*

1._____ 2._____

3._____ 4._____

List stresses or emotional issues you are currently dealing with:

1._____ 2._____

3._____ 4._____

IF YOU ARE PREGNANT OR POST-PARTUM

Due or Birth Date: _____ Number of Pregnancies: _____ Number of Births: _____

Did you experience any complications with a prior pregnancy? If yes, please explain:

_____

Prenatal Care Provider: _____ Phone Number: _____

Are you under the care of a fertility specialist? □ Yes _____ □ No

If you are currently working, when do you plan to begin maternity leave? _____

Do you have a history of?

☐ Edema	☐ Preterm labor	☐ Varicose Veins
☐ Morning sickness/nausea	☐ Thyroid problems	☐ Diabetes
☐ Carpal tunnel syndrome	☐ Sinus congestion	☐ Sciatica
☐ Heartburn	☐ Hemorrhoids	☐ Mental/Emotional Concerns
☐ Blood Clots	☐ Blood Pressure	☐ Placental Dysfunctions

FERTILITY MASSAGE

Day 1 of Cycle: _____ Ovulation Day:_____ Number of Pregnancies_____

Do you chart your cycle? □ Yes □ No Has your spouse/partner been checked? □ Yes □ No

Are you working with a fertility doctor? □ Yes _____ □ No

What procedures have been done or are planned?

Are you currently taking any medication? □ Yes □ No If yes, please explain: _____

Doctor:_____ Phone Number: _____

Are you using other complementary medicines to help prepare you for conception? □ Yes □ No

If yes, please explain: _____

What methods? _____

Have you ever been told your uterus is tilted or is unusual? □ Yes □ No If yes, please explain: _____

Do you have a history of?

☐ Endometriosis	☐ PCOS	☐ STDs
☐ Constipation	☐ Irregular cycles	☐ PMS
☐ Pelvic surgeries	☐ Hormone Imbalances	☐ Mental/Emotional Concerns
☐ Pelvic Inflammatory Disease	☐ Uterine Fibroids	☐ Fallopian tube issues

By signing below, I understand and agree that this massage is not a replacement for medical care and that no diagnosis will be made. I affirm that I have come to this place to avail myself of the service of Massage Therapy, and have not nor will not ask her/him to do anything illegal in the State of IL, nor anything against his/her personal/professional moral code. I also understand that I am responsible for paying for any services rendered, at the time of service.

_____

Signature Date