

# Radiant Reflections

## Confidential Case History

Name \_\_\_\_\_ Date of first visit: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

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

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  M  F

Occupation: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Have you had massage therapy before? \_\_\_\_\_ Where and by whom? \_\_\_\_\_

What is your major area of concern? \_\_\_\_\_

When did you first notice it? \_\_\_\_\_ What brought it on? \_\_\_\_\_

What activities aggravate it? \_\_\_\_\_

Is this condition getting worse?  Yes  No Does it interfere with work?  Yes  No

Does it interfere with recreation?  Yes  No

What do you believe is wrong with you? \_\_\_\_\_

What have you done to get relief? \_\_\_\_\_

Has there been a medical diagnosis?  Yes  No Exam?  Yes  No

Bloodwork?  Yes  No X-Rays?  Yes  No Other? \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_

What are your other areas of pain or concern? \_\_\_\_\_

### PAST HISTORY:

Have you ever had a similar problem before?  Yes  No When? \_\_\_\_\_

What caused those episodes? \_\_\_\_\_

What relieved them? \_\_\_\_\_

What was the previous diagnosis? \_\_\_\_\_

What treatments? \_\_\_\_\_

Did they help?  Yes  No Have you had massage therapy?  Yes  No

Are you presently under a doctor's care?  Yes  No

If so, for what condition? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Are you taking any medications?  Yes  No

If so, please list: \_\_\_\_\_

Do you take:  Laxatives  Sedatives  Sleeping Pills  Insulin  Blood Thinners

Aspirin  Vitamins  Herbs  Minerals  Birth Control Pills

Other \_\_\_\_\_

Indicate the following habits with: **H=Heavy M=Moderate L=Light N=None**

\_\_\_\_\_ Alcohol \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Tobacco \_\_\_\_\_ Colas

\_\_\_\_\_ White Flour Products \_\_\_\_\_ Sugared Products \_\_\_\_\_ Exercise

Cravings? \_\_\_\_\_

Previous Operations \_\_\_\_\_

Previous Broken Bones \_\_\_\_\_

Previous Accidents or Injuries \_\_\_\_\_

Do you bruise easily? \_\_\_\_\_

**Circle** any of the following you are **CURRENTLY** having difficulty with.  
Underline any of the following that you have had difficulty with in the **PAST**.

Headaches	Muscle spasm in neck	Cold sweats
Shooting pains in the head	Grating in neck	Liver trouble
Sinus trouble	Tightness in shoulder muscles	Gallbladder trouble
Loss of smell	Neuritis in shoulders & arms	Indigestion
Loss of taste	Pins and needles in arms & hands	Intestinal gas
Tightness in throat	Cold hands	Constipation
Inflammation of throat	Chest pains	Kidney trouble
Thyroid trouble	Shortness of breath	Bladder trouble
Face flushed	T.B.	Diabetes
Twitching face	Heart pain	Cancer
Loss of memory	Heart palpitations	Sleeping problems
Fatigue	Heart attack	Painful joints
Depression	High blood pressure	Swollen joints
Head feels too heavy	Low blood pressure	Arthritis
Dizziness	Anemia	Herniated/bulging disk
Fainting	Blood clots/Phlebitis	Pinched nerve in back
Loss of balance	Rheumatic fever	Pins & needles in legs
Ringing in ears	Nervous stomach	Swollen ankles
Wear glasses	Ulcers	Cold feet
Light bothers eyes	Nervousness	Pains in legs & feet
Hayfever	Inner tension	Numb hands or feet
Asthma	Skin disorders	Sciatica
Epilepsy	Varicose veins	Other _____
Excessive perspiration		

**MALE ONLY**

- Burning during urination
- History of prostate trouble
- Urination difficult or dribbling
- Frequent night urination
- Pain in the groin area
- Diminished sex drive
- Burning or pain during orgasm

**FEMALE ONLY**

- ARE YOU PRESENTLY PREGNANT?  Yes  No
- Pre-menstrual tension or depression
- Painful menstruation-cramps
- Menses excessive and/or prolonged
- Menses scanty or missing
- Vaginal discharge
- Painful breasts
- Menopausal hot flashes, etc
- How many pregnancies? \_\_\_\_\_
- Form of birth control: \_\_\_\_\_
- PMS: Explain: \_\_\_\_\_

Do you have a history of constipation?  Yes  No      How many bowel movements per day? \_\_\_\_\_

Age of mattress? \_\_\_\_\_  Comfortable     Uncomfortable     Waterbed

Do you use a foam pillow? \_\_\_\_\_      Do you sleep on your:  side     back     stomach

Do you wear:  Heel lifts     Sole supports     Arch supports     Inner soles

**Client's Payment Agreement:**

*I understand that fees are due at the time of treatment unless other arrangements are made. I also understand that if I cancel an appointment within 24 hours of the visit, the full price of the visit will be charged.*

Signature \_\_\_\_\_

Date \_\_\_\_\_