Peak Performance Wellness

Confidential Case History & Intake Form

Patient Information

Name:_____ Date of session: _____

Address:_____ City/State:_____

Email Address:_____ Phone: _____

Age: _____ Birthdate: _____ Gender: Male_____Female_____

Marital Status:_____ # Children:_____

Occupation:_____ Company :_____

How did you hear about us? _____

Have you had massage therapy before? Yes_____No_____

What would you like to accomplish during your massage? *(sports massage, specific pain reduction, general relaxation, increase range of motion)*_____

_____

_____

Current Concerns

What is your major area of pain/concern?_____

When did you first notice it? _____ What brought it on? _____

What activities irritate it?_____

Is this condition getting worse?_____ Does it interfere with work _____ sleep _____ recreation _____

What have you done to get relief?_____

Has there been a medical diagnosis? _____ Exam?_____ Blood work ____? X-rays?_____MRI?_____

What was the diagnosis?_____ By whom? _____

_____

Past History

Previous operations or cosmetic surgeries and dates:_____

_____

Previous broken bones or dislocations:_____

Previous accidents or injuries:_____

_____

_____

_____

Medications/Supplements

Are you taking any medications? ____Yes ____ No

Muscle relaxers ____ Pain pills ____ Blood thinners____ Insulin____ Aspirin____Sleeping pills ____

Sedatives ____ Vitamins ____ Minerals ____ Herbs ____ Others (list them): _____

_____

Indicate the following habits with: H-heavy, M-moderate, L-light, N-none

Exercise _____ Sitting _____ Stress _____ Alcohol _____ Coffee _____ Tea _____ Tobacco _____

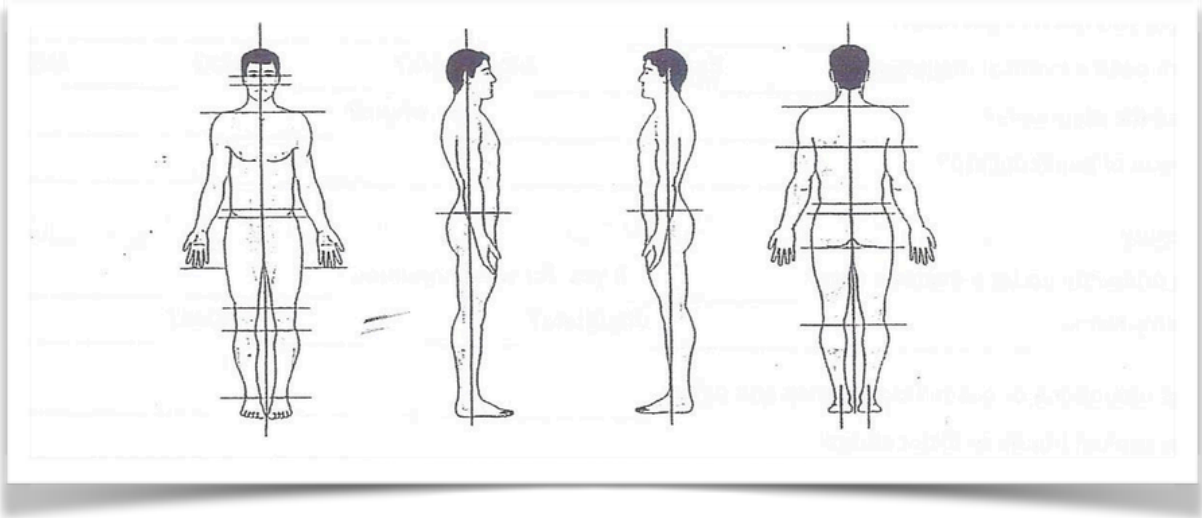
Soda _____ Artificial sweeteners _____ Water _____

Check all of the following you are currently having difficulty with. **Mark an X** for any you have had past problems with.

____Neck pain	____Mid back pain	____Lower back pain	____ tight shoulders
____foot pain	____TMJ pain	____Headaches	____Recent surgery
____Sciatic pain	____Joint pain	____Cancer	____ Allergies
____Varicose veins	____Numbness	____Skin conditions	____Recent injuries
____Sprains/strains	____Insomnia	____H/L blood pressure	____Blood clots
____Diabetes	____Major accident	____Hepatitis	____Muscle spasms

____OTHER:_____

PLEASE (SHADE IN) AREAS OF PRESENT PAIN/DISCOMFORT



I understand that payment is due at the time of treatment, unless prior arrangements have been made.

I agree to give Peak Performance Wellness 24 hours notice of cancellation or change of appointment. If less than 24 hours notice is given, I agree to pay for the session if Peak Performance Wellness is unable to fill the appointment time with another client. (Cases of extreme emergency are considered exceptions.)

Signature _____ Date _____