



# 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: \_\_\_\_\_

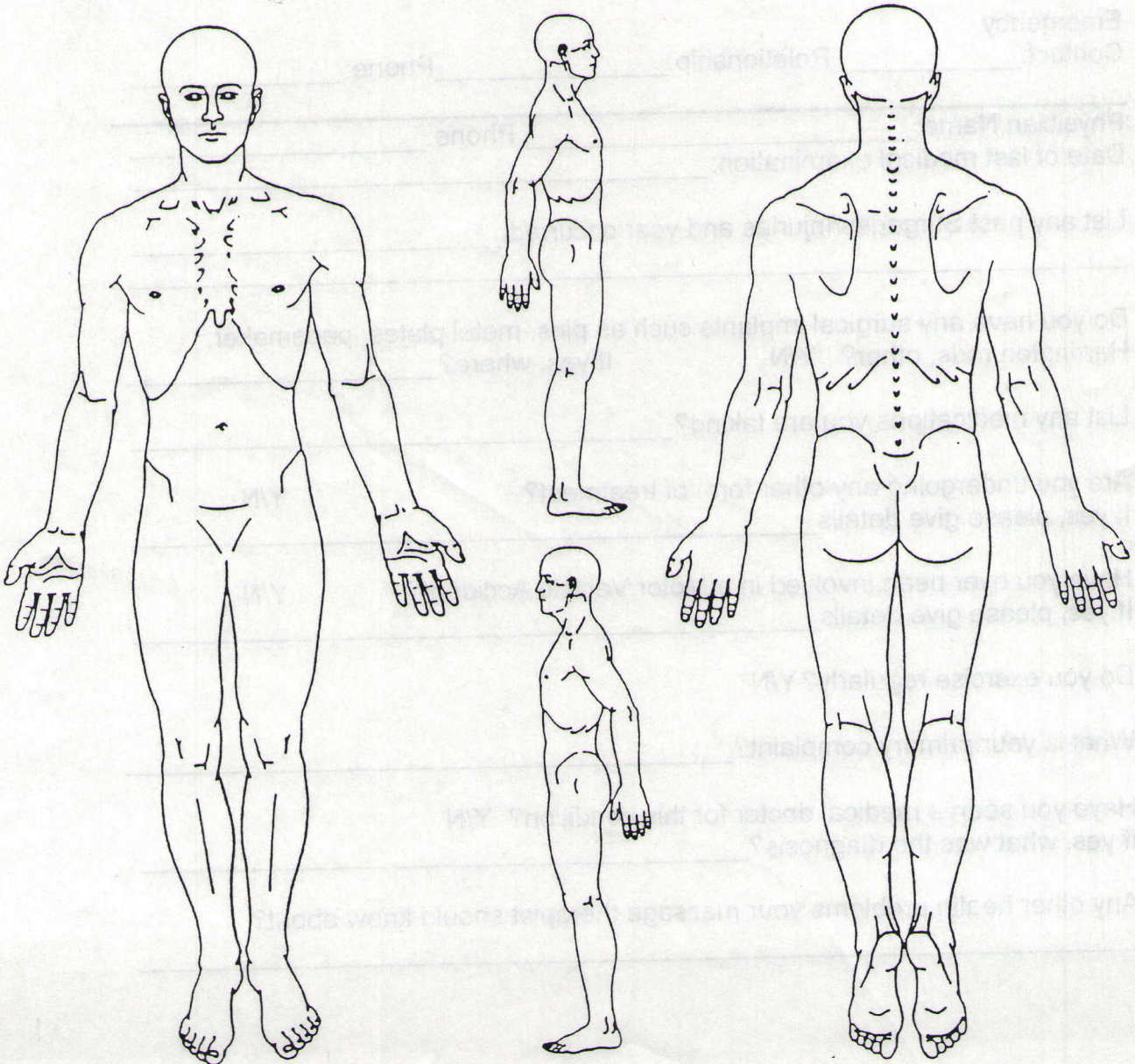
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

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 or 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 consciousness

**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: