NEW DIRECTIONS
Health & Bodywork Professionals, Inc.

Confidential Case History

Date

	Home Phone #
Name	**Cell/Wk #**

Address

Date of Birth **M □ F □** **Marital Status** **# of Children**

e-mail address:	

Occupation

Who is responsible for payment? **How did you hear about us?**

Have you had a massage before? □ yes □ no

What is your major area of pain or concern?

When did you first notice it?

What brought it on?

Is this condition improving? □ yes □ no **Does it interfere with □work? □sleep? □recreation?**

Have you seen a doctor for this condition? □ yes □ no Was there a diagnosis? □ yes □ no If yes, what was the diagnosis?	**Indicate any tests you have had & the results.** **MRI □** **X-ray □** **Blood work □** **Other □**

Are you pregnant? □Yes □No **If yes, how many weeks?**

Please list any other concerns or problems.

Are you currently under a doctor's care? □ yes □ no **If yes, please indicate for what condition & his/her name.**

Please list any medications you are currently taking.

Please list any nutritional supplements or herbs you are currently taking.

Please list your physical activities (i.e. running, yoga, swimming, walking).

Please list any surgical procedures you have experienced.

Please list previous broken bones.

Please list previous accidents or injuries.

Please circle any of the following symptoms or conditions you are currently experiencing or have had in the past.

Headaches: sinus, tension, migraines	Rheumatic fever	**Liver trouble**
Shooting pains in head	Reproductive problems	**Gallbladder trouble**
Loss of smell	Nervous stomach	**Kidney trouble**
Loss of taste	Ulcers	**Bladder trouble**
Throat problems	Indigestion, gas	**Diabetes**
Thyroid disease	Constipation, diarrhea	**Cancer**
Flushed face	Nervousness	**Sleeping problems**
Twitching of face	Inner tension	**Painful or swollen joints**
Loss of memory	Skin disorders, psoriasis, fungus	**Arthritis**
Fatigue	Cold sweats	**Herniated or bulging disk**
Depression	Grating in neck	**Pinched nerves in back**
Dizziness, fainting	Muscle spasms in neck	**Pins & needles in legs**
Loss of balance	Tightness in shoulder muscles	**Swollen ankles**
Ringing in ears	Pins & needles in arms or hands	**Pain in legs and feet**
Jaw pain or TMJ dysfunction	Cold hands/feet	**Numb hands and feet**
Hay fever	Shortness of breath	**Varicose veins**
Asthma	Tuberculosis	**Anemia**
Epilepsy or other seizures	High blood pressure	**Blood clots, phlebitis**
Excessive perspiration	Low blood pressure	**Stroke**
Heart palpitations	Sciatica	**Allergies**
Heart attack	Scoliosis	**Other** _____
Chest pains	Recurring infections	_____

I _____ hereby voluntarily request and consent to treatment methods offered by New Directions. I acknowledge and consent that such treatment methods may include but not be limited to: therapeutic massage, stretching, hydrotherapy and recommended self care.

I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I also understand that I am responsible for payment if third party payment is not made.

I agree to give 24 hour notice of cancellation of appointment. If less than 24 hours notice is given, I agree that the therapist may charge for the time if unable to fill the appointment with another person.

Signature	**Date**