Gibson Massotherapy

Confidential Case History

Dear Client: Please complete BOTH SIDES of this questionnaire. Thank you!

Name _____ **Date** _____

Street address_____

City _____ **State** _____ **Zip**_____

Home Phone _____ **Work Phone** _____ **Date of Birth** _____

Cell Phone _____ **Email** _____

How did you hear about Randall Gibson? _____

Occupation _____ Spouse Name _____

Are you taking any medication? _____Vitamins, minerals or other supplements?_____

(Please specify) _____

In case of emergency, contact: _____

Please describe your present symptom or major complaint **(if none, turn this sheet over)**

_____

Has there been a medical diagnosis? _____ What is it? _____

When was it made? _____ By whom? _____

When did you first notice the complaint? _____

What brought it on? _____

What aggravates the condition? _____

Is this condition getting better? _____ Worse? _____ Constant? _____ Comes and goes? _____

What have you done to get relief? _____

_____

Do you have difficulty with any of the following?

GENERAL

_____ Allergy
_____ Cancer
_____ Chills
_____ Convulsions
_____ Depression
_____ Diabetes
_____ Dizziness
_____ Epilepsy
_____ Fainting
_____ Fatigue
_____ Fever
_____ Fibromyalgia
_____ Goiter
_____ Headache
_____ Hypoglycemia
_____ Immune Disorder
_____ Loss of Sleep
_____ Nervousness
_____ Numbness/Tingling
_____ Stress
_____ Sweats / Tremors
_____ OTHER

GASTRO-INTESTINAL

_____ Acid Reflux
_____ Belching or gas
_____ Colitis / IBS
_____ Constipation / Diarrhea
_____ Difficult Digestion
_____ Gall Bladder trouble
_____ Hemorrhoids
_____ Kidney problems
_____ Liver problems
_____ Stomach / Ulcer
_____ OTHER

MUSCLE AND JOINT

_____ Arthritis / Bursitis
_____ Hand / Wrist / Elbow trouble
_____ Foot / Ankle / Knee trouble
_____ Fractures
_____ Gout
_____ Low Back / Hip Pain
_____ Neck Pain or Stiffness
_____ Upper Back / Shoulder Pain
_____ Sciatica
_____ Strains or Sprains
_____ Swollen joints
_____ OTHER

EYES, EARS, NOSE, THROAT

_____ Eye / Vision problems
_____ Ear noises
_____ Frequent Colds
_____ Frequent Earaches
_____ Frequent Nosebleeds
_____ Frequent Sore Throat
_____ Hay Fever / Allergies
_____ Chronic Hoarseness
_____ Sinus Infection
_____ OTHER

RESPIRATORY

_____ Asthma
_____ Chest pain
_____ Chronic Cough
_____ Difficulty Breathing
_____ Emphysema
_____ OTHER

CARDIO-VASCULAR

_____ Hardening of Arteries
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Heart trouble
_____ Poor Circulation
_____ Stroke
_____ Varicose Veins
_____ OTHER

SKIN

_____ Bruise Easily
_____ Dryness
_____ Eczema
_____ Itching
_____ Psoriasis
_____ OTHER

GENITO-URINARY

_____ Bladder Infections
_____ Blood in Urine
_____ Frequent Urination
_____ Painful Urination
_____ Prostate trouble
_____ OTHER

WOMEN ONLY

_____ Excess Menstrual flow
_____ Hot Flashes
_____ Irregular Cycle
_____ Lumps in Breast
_____ Painful Menstruation
_____ OTHER

Other _____

List surgeries, broken bones, Infectious diseases

_____

Guidelines and Policies from the Ohio Medical Board (to slow the spread of COVID-19)

1. You have the option of waiting in your car if you prefer. If you choose to do that, call me when you arrive at the parking lot. I will call you back when I am ready for you.
2. Please bring your own water to drink. Shared drinking water dispensers are now banned.
3. Face masks are required for your appointment. If you don't have one, I can provide one for $1.
4. Please come alone if possible or maintain a six-foot distance between you and any other adult unless you require their assistance.
5. If practical, please pay online when you make your appointment. Paying in advance helps to minimize any contact that could spread disease.
6. When you arrive at the office, I will check your forehead temperature and ask a series of questions (unless you have filled out the questionnaire in advance). If you have symptoms, a fever, or have been recently exposed to someone with COVID-19, your session may have to be postponed.

These policies are designed to keep you and everyone else safe. Thank you for respecting them!

Please fill out the questionnaire on the reverse of this page and bring it (along with your history form) to your appointment.

Gibson Massotherapy
3250 W Market St, Ste. 104
Fairlawn, OH 44333
330-701-8780

COVID-19 Questions

Patient Name	**Date**		**Date**	
Have you felt hot or feverish in the last 21 days?	YES	NO	YES	NO
Have you had any shortness of breath, cough, or flu-like symptoms?	YES	NO	YES	NO
Have you experienced a recent loss of taste or smell?	YES	NO	YES	NO
Have you been in contact with any confirmed COVID-19 positive patients?	YES	NO	YES	NO
Have you travelled in the past 21 days? If so, where?	YES	NO	YES	NO

Positive response to any of these would warrant a deeper discussion with your therapist before proceeding with your bodywork session