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

_____

COVID-19 Safety Requirements

1. Face masks are required for your appointment.
2. Please bring your own water to drink. Shared water dispensers are no longer available.
3. Please maintain a six-foot distance between you and any other adult unless you require their assistance.
4. 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 COVID-19, your session will have to be postponed.

Please circle the correct answers and bring this page to your appointment.

Print Name **Date**

Do you have a fever (or have you felt hot or feverish in the last 21 days)?	YES	NO
Have you had any shortness of breath, digestive issues, or flu-like symptoms?	YES	NO
Have you experienced a recent loss of taste or smell?	YES	NO
Have you been in contact with any confirmed COVID-19 positive patients?	YES	NO

If you answered YES to any of the above, please call to discuss it before your appointment.

Are you fully vaccinated against COVID-19?	YES	NO

_____

Signature