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

Are you Fully Vaccinated against COVID-19 _____Yes _____No

COVID-19 Safety Requirements

1. Face masks are required for your appointment unless you are fully vaccinated.
2. Shared water dispensers are not available in the office. There is a water fountain nearby.
3. Please maintain a six-foot distance between you and any other adult in the waiting area.
4. When you arrive at the office, I will check your temperature. If you have symptoms, a fever, or have been recently exposed to COVID-19, your session may have to be postponed.

Please circle the correct answers and bring this entire form to your first 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 session.

All of the information provided on this form is accurate to the best of my knowledge.

____

Signature