Serenity Now Massage Therapy **Date:**

Name _____**Date of Birth** ___/___/___ **Age:** ___ **Sex:** ^**Male** ^**Female**
Address_____
City/ Province/ Postal Code _____
Telephone (home)_____**(work)**_____**Occupation**_____
Emergency Contact Person/Relationship_____
Phone#_____
Physician_____ **Phone#**_____
Main Complaint (symptoms, diagnosis, duration, etc.)

Do you have a medical diagnosis? ❑ **Yes** ❑ **No ... if yes:** _____

When did this first begin? _____

Were there any related circumstances: emotional, physical or mental stress? Or were you ill when this began?

_____

_____

What kind of treatments have you tried?

_____

_____

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

_____

_____

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods,.)

_____

_____

Are you pregnant? ❑ **Yes** ❑ **No** **Prone to fainting?** ❑ **Yes** ❑ **No** **Have you eaten today?** ❑ **Yes** ❑ **No**

Have you had acupuncture before? ❑ **Yes** ❑ **No** **Chinese Herbals?** ❑ **Yes** ❑**No**

Most recent blood pressure reading? __/__ Taken when?_____

Significant Trauma (physical or emotional)

_____

Birth History (prolonged labor, forceps delivery, complications, etc.)

_____

Surgeries (please include date of procedure)

_____

Allergies (chemical, environmental, food, drugs, etc.)

_____

Medications (names & dosages) please attach an additional page if necessary.

_____

Vitamins/Supplements/Herbs

_____

Do you have a regular exercise program?

APPETITE ❑**Poor** ❑ **Low** ❑ **Heavy** ❑ **Normal** ❑ **Changed**

What do you eat in a typical day?

Any particular diet (Vegan, Vegetarian, Low Carb ect...)

Foods you tend to Crave:

THIRST **Do you prefer your drinks:** ☐**Ice cold** ☐**Hot** ☐**Room temperature**

 # Of glasses consumed daily? _____Water_____Coffee/Tea_____Pop_____Juice_____Milk

Do you have??
☐ **Normal thirst** ☐ **Thirsty all the time** ☐ **Thirst with no desire to drink** ☐ **Never thirsty**

HABITS: daily intake?

_____Alcohol **_____Cigarettes** **_____Other_____**

Personal History Please check any conditions or symptoms you have now.

☐ **Anemia**
☐ **Arthritis**
☐ **Head Injury**
☐ **Skin disorder**
☐ **Stroke**
☐ **Cancer**
☐ **Ulcer**
☐ **Chronic Fatigue**
☐ **Gastritis/Pancreatitis**
☐ **Candida**
☐ **Hay fever / allergies**
☐ **Liver/Gall Bladder Disease**
☐ **Prostate**
☐ **Hypo/Hyperglycemia**
☐ **High/Low Blood Pressure**
☐ **Diabetes**
☐ **Seizures/Epilepsy**
☐ **TB**
☐ **Asthma**
☐ **Immunosupression**
☐ **Heart Disease**
☐ **Osteoporosis**
☐ **Kidney Disease/Stones**
☐ **Raynaud's Disease**
☐ **Diverticulitis/IBS**
☐ **Hepatitis**
☐ **Thyroid Imbalance**
☐ **Emphysema**

Family Medical History Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

☐ **Diabetes ___**
☐ **High Blood Pressure ___**
☐ **Other_____**
☐ **Seizures ___**
☐ **Allergies ___**
☐ **Heart Disease ___**
☐ **Cancer ___**
☐ **Stroke ___**
☐ **Asthma ___**

Please **check** if you have had any of these items listed below in the last **year or previously**

General

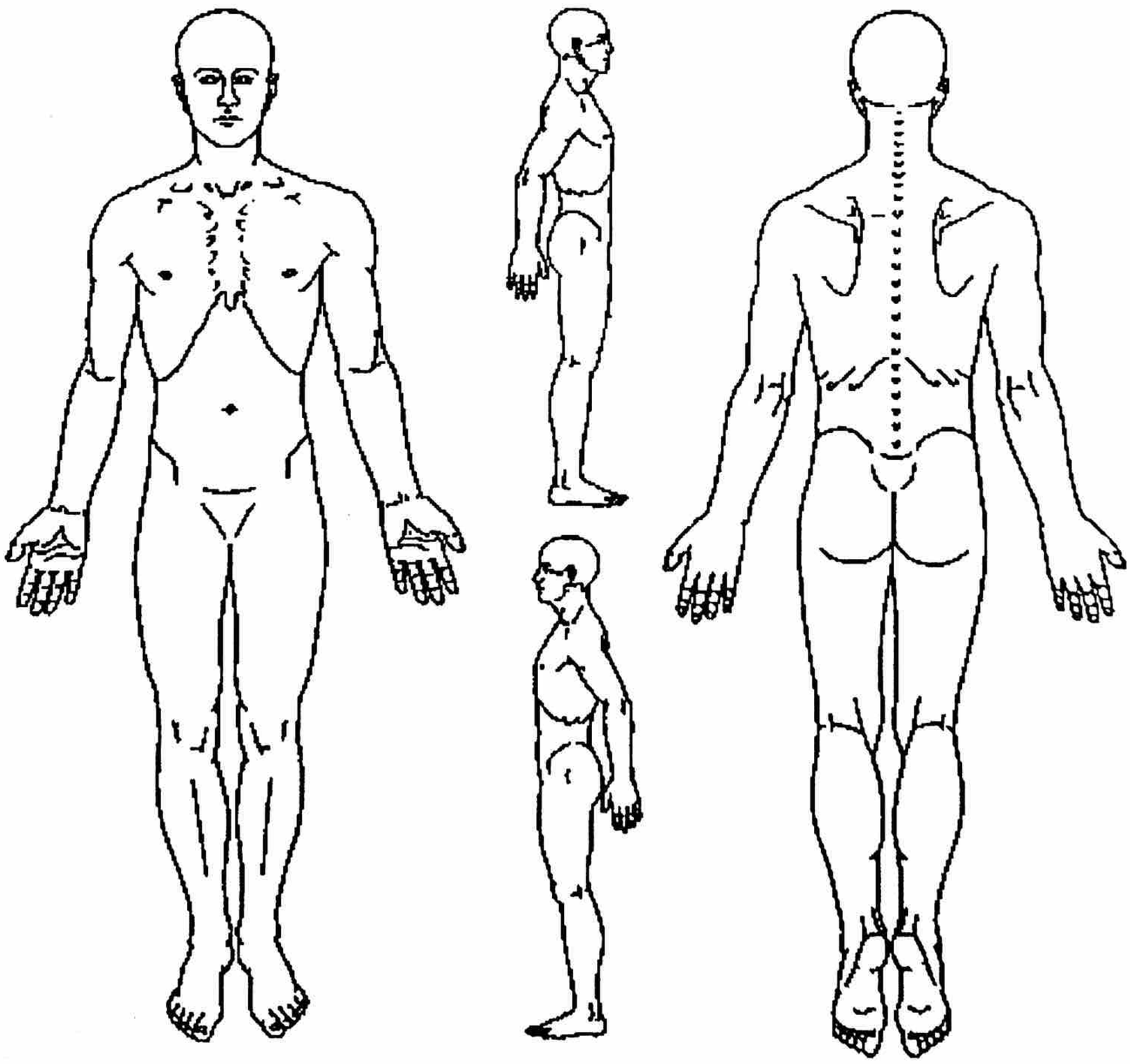
☐ **Poor Appetite**
☐ **Chills**
☐ **Cravings**
☐ **Bleed/Bruise easily**
☐ **Muscle weakness**
☐ **Poor Sleeping**
☐ **Night Sweats**
☐ **Localized Weakness**
☐ **Weight loss/gain**
☐ **Sudden energy drop**
☐ **Fatigue**
☐ **Sweats Easily**
☐ **Poor Balance**
☐ **Peculiar tastes/smells**
☐ **Strong thirst**
☐ **Fevers**
☐ **Tremors**
☐ **Change in appetite**
☐ **Dental/gum problems**

Musculoskeletal

☐ **Sprains/Strains**
☐ **Tendonitis**
☐ **Shoulder pain**
☐ **Rotator Cuff**
☐ **Muscle pain**
☐ **Hand/wrist pain**
☐ **Sciatica**
☐ **Muscle weakness**
☐ **Carpal Tunnel**
☐ **Foot/ankle pain**
☐ **Bursitis**

☐ **Back pain Low___ Middle___ Upper___**

Pain Diagram (please mark all areas of pain on diagram below)
A=aching B=burning N=numbness P=pins and needles
S= stabbing pain O=other type of sensation



Skin and Hair

☐ **Rashes** ☐ **Ulcerations** ☐ **Hives/Allergic Dermatitis** ☐ **Itching**

☐ **Eczema/Psoriasis** ☐ **Dandruff** ☐ **Loss of hair** ☐ **Recent moles**

☐ **Skin discoloration** ☐ **Acne** ☐ **Change in skin/hair texture** ☐ **Face flushing**

Head and Senses

☐ Dizziness
☐ Eye pain
☐ Color Blindness
☐ Ringing in ears
☐ Nose bleeds
☐ Headaches
☐ Difficulty swallowing
☐ Poor vision
☐ Cataracts
☐ Poor hearing
☐ Grinding teeth
☐ Jaw clicks/locks
☐ Deafness
☐ Migraines
☐ Night Blindness
☐ Blurred vision
☐ Spots in front of eyes
☐ Facial pain
☐ Eye Strain
☐ Earaches
☐ Sinus
☐ Cankers

problems

Location:
Sensation:
Better/Worse with Pressure:

Cardiovascular

☐ Chest pain or pressure
☐ Cold hands/feet
☐ Shortness of breath
☐ High blood pressure
☐ Low blood pressure
☐ Irregular heart beat
☐ Swelling of hands/feet
☐ Varicose/spider veins
☐ Spontaneous sweating
☐ Palpitations at rest
☐ Blood clots
☐ Pressure in chest
☐ Dizziness
☐ Fainting
☐ Phlebitis

Respiratory

☐ Cough/Wheezing
☐ Shortness of Breath
☐ Coughing blood
☐ Pain with deep inhalation
☐ Asthma
☐ Tight sensation in chest
☐ Bronchitis
☐

☐ Difficult inhale/exhale
☐ Difficulty breathing when lying down
☐ Production of phlegm... what color? _____

Gastrointestinal

☐ Nausea
☐ Gas
☐ Blood in stool
☐ Indigestion
☐ Hemorrhoids
☐ Bloating/Edema
☐ Abdominal pain/cramps
☐ Changes in appetite

Poor appetite
☐ Excessive appetite

☐ Vomiting
☐ Belching
☐ Bad breath
☐ Chronic laxative use
☐ Acid reflux/GERD
☐ Celiac
☐ Diarrhea ☐ Constipation
☐ Black stools
☐ Rectal pain
☐ Loose stools (>2 per day)
☐ Hernia
☐ IBS/Crohn's Disease/Colitis
☐

Genito-Urinary

☐ Pain on urination

☐ Frequent urination

☐ Blood in urine

☐ Urgent urination

☐ Unable to hold urine flow

☐ Kidney stones

☐ Scanty flow

☐ Copious

☐ Urinary tract infection

☐ Burning

☐ Prostatitis

☐ Dribbling

☐ Night urination... What time?_____ How often?_____

Male Reproductive

☐ Impotence

☐ Vasectomy

☐ Increased Libido

☐ Decreased Libido

☐ Infertility

☐ Low sperm count

☐ Low Sperm motility

☐ Premature ejaculation

Female Reproductive

☐ Endometriosis

☐ Long periods

☐ Painful menstruation

☐ Increased Libido

☐ Heavy periods

☐ Decreases Libido

☐ Light periods

☐ Hormone replacement

☐ Clots

☐ Uterine Fibroids

☐ Breast lumps

☐ Vaginal discharge

☐ Fibrocystic breast tissue

☐ Infertility

☐ PMS

☐ Days between cycles

☐ Ovarian cysts

☐ Breast tenderness

☐ Yeast/Bladder infections

☐ Irregular Period

☐ Menopause

☐ Hot flashes - Daytime

☐ Night Sweats

Do you practice birth control?_____What type?_____ How long?_____

Female Reproductive

☐Long periods
☐Painful menstruation

☐Heavy periods
☐Light periods
☐Clots
☐Breast lumps

☐Vaginal discharge
☐Infertility
☐Days between cycles
☐Breast tenderness

☐Irregular Period
☐Menopause
☐Hot flashes - Daytime
☐Night Sweats

☐Endometriosis

☐Increased Libido

☐Decreases Libido
☐Hormone replacement
☐Uterine Fibroids

☐Fibrocystic breast tissue
☐PMS
☐Ovarian cysts
☐Yeast/Bladder infections

Do you practice birth control?_____What type?_____ How long?_____

Neuropsychological

☐Seizures
☐Areas of numbness
☐Lack of coordination
☐Depression
☐Anxiety/Panic attacks
☐Seasonal Affective Disorder (SAD)
☐Nervousness
☐Tics/twitching

☐Loss of balance

☐Poor memory

☐Bad temper/irritable

☐ADD/ADHD
☐Mood swings

☐Vertigo/Dizziness

☐Concussion

☐Easily Stressed

☐Manic Depression
☐ Bipolar

Comments: Please inform me of any other problems you would like to discuss.