BIODYNAMIC THERAPIES, LLC

CONFIDENTIAL CASE HISTORY

Name_____ Phone Number_____

Age_____ Date of Birth_____ M__F__ Marital Status_____

Occupation_____ Date of First Visit_____

How did you hear about us?_____

Have you had massage therapy before?_____

What is your major area of concern?_____
_____
_____
When did you first notice it?_____What brought it on?_____
What activities aggravate it?_____
Is condition getting worse? Yes__ No__ Does it interfere with work?_____
Sleep?_____ Recreation?_____
What do you believe is the problem?_____
What have you done to find relief?_____
Have you obtained a medical diagnosis?__Exam?__Blood work?__X-rays?_____
What was the diagnosis?_____By whom?_____
_____
_____

PAST HISTORY:
Have you ever had a similar problem before?____ When?_____ What caused it?_____ What relieved it?_____
What was the diagnosis?_____ What treatments?_____
_____ Did they help?_____
Are you presently under a Doctor's care?_____ If so, for what condition?
_____
Name of Physician_____Phone_____
Are you taking any medications?_____
_____

Are you taking any:
( ) Laxatives ( ) Sedatives ( ) Sleeping Pills ( ) Insulin ( ) Blood Thinners
( ) Aspirin ( ) Vitamins ( ) Herbs ( ) Minerals
( ) Birth Control Pills ( ) other _____
Indicate the following habits with: H-Heavy M-Moderate L-Light N-None
__Alcohol __Coffee __Tea __Tobacco __Colas __Sugared products
__Nutrasweet __White flour products __Exercise Cravings_____
Previous surgeries_____
_____
Previous fractures_____
_____
Previous accidents or injuries_____
_____

CIRCLE any of the following that you are CURRENTLY having difficulty with. UNDERLINE any that you have had past problems with.

Headaches	Muscle spasms in neck	Cold sweats
Shooting pains in neck	Grating in neck	Liver trouble
Sinus trouble	Tightness in shoulder muscles	Gallbladder trouble
Loss of smell	Neuritis in shoulders and arms	Indigestion
Loss of taste	Tingling in arms and hands	Intestinal gas
Tightness of throat	Cold hands	Constipation
Inflammation of throat	Chest pains	Kidney trouble
Thyroid trouble	Shortness of breath	Bladder trouble
Flushing of face	Tuberculosis	Diabetes
Twitching of face	Heart pain	Cancer
Loss of memory	Heart palpitations	Sleeping problems
Fatigue	Heart attack	Painful joints
Depression	High blood pressure	Swollen joints
Head feels to heavy	Low blood pressure	Arthritis
Dizziness	Anemia	Herniated/bulging disk
Fainting	Blood Clots/Phlebitis	Pinched nerve in back
Loss of balance	Rheumatic fever	Pins & needles in legs
Ringing in ears	Nervous stomach	Swollen Ankles
Wear corrective lens	Stomach trouble	Cold feet
Light sensitivity	Ulcers	Pains in legs & feet
Hay fever	Nervousness	Sciatica
Asthma	Inner tension	Numbness in hands/feet
Epilepsy	Skin disorders	Varicose veins
Excessive perspiration	Accidents	Other:_____

Male only:	Female Only:
Burning during urination_____	Are you presently pregnant?_____
History of prostate trouble_____	Pre-menstrual tension/depression _____
Urination difficult or dribbling_____	Painful menstruation/cramps_____
Frequent urination at night_____	Menses excessive/prolonged_____
Pain in groin area_____	Menses scanty or absent_____
Diminished sex drive_____	Painful breasts_____
Tailbone injuries_____	Menopausal hot flashes_____
Other_____	Number of pregnancies_____
	Form of birth control_____
	Other_____

Do you have a history of constipation?_____ How many bowel movements per day?_____
Age of mattress____ Comfortable____ Uncomfortable____ Waterbed____
Do you use a foam pillow?____Do you sleep on: Side__ Back__ Stomach__
Are you wearing Heel lifts__ Sole supports__ Arch supports__ Inner soles __

Date_____ Signature _____