**Ishman BodyCare Center** 608 S. Washington Street, Naperville IL 60540
630-355-5125 or 888-395-7140 **www.ibodycare.com**

# Confidential Personal Health Information

## Personal Information

Name _____

Home Address _____

City _____

State _____ Zip_____ Birthday _____

Home Phone _____

Home Email _____

Work Phone _____

Work email _____

Occupation _____

If applicable:
Referring Physician _____

Physician Phone _____

Physician Fax _____

Written Prescription? Yes / No

Written for what? _____

Diagnosis Code _____

Insurance Co. _____

Will you be filing for insurance reimbursement for massage therapy? Yes / No / Don't Know

Emergency Contact _____ Emerg. Contact Phone _____

How did you hear about Ishman BodyCare Center?_____

## Massage History/Treatment

Have you ever had a professional massage? _____ Yes_____ No
If yes, frequency _____ Date of last massage _____

What results do you want from your massage sessions?

_____

What areas of your body absorb/carry the most stresses or need the most attention?

_____

Are there any areas that you would prefer not to be massaged?

_____

Are you currently seeing a medical practitioner? Why?

_____

Please list stress reduction and exercise activities and frequency

_____

Please list current medications, including aspirin, ibuprofen, etc.

_____

## Previous History Please include year and treatment received.

Surgeries _____

Accidents/injuries _____

## Health History

**Musculo-Skeletal**
- Bone/joint disease _____
- Tendinitis _____
- Bursitis _____
- Arthritis _____
- Sprains/strains _____
- Low back/hip _____
- Knee/leg pain _____
- Neck/shoulder/arm pain _____
- Headaches / Injuries _____
- Jaw Pain/TMJ _____
- Spasms/Cramps _____

**Circulatory**
- Heart condition _____
- Varicose veins _____
- High/low blood pressure _____
- Other _____

**Infectious disease**
- Disease name(s) _____

**Skin**
- Allergies _____
- Athlete's foot _____
- Other _____

**Digestive**
- Constipation _____
- Irritable Bowel _____
- Diarrhea _____

**Nervous System**
- Numbness/tingling _____
- Sleep disorders _____
- ADD / ADHD _____
- Other _____

**Reproductive**
- Pregnant? _____
- PMS _____
- Menstruating _____
- Other _____

**Other**
- Breathing difficulty/sinus problems _____
- Allergies _____
- Depression _____
- Eating disorders _____
- Drug/alcohol addiction _____
- Nicotine/caffeine addiction _____
- Chronic pain _____
- Other _____

It is my choice to receive massage therapy. I realize the treatment being given is for the well being of my body and mind. This includes stress reduction and relaxation/awareness, relief from muscular tension, spasm, or pain, increase of circulation, and increased range of motion and flexibility. I agree to communicate with my practitioner at any time I have concerns of being compromised.

I understand that massage practitioners do not diagnose illness, disease, or other physical or mental disorders, or perform spinal manipulation.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

**Signature** _____ **Date** _____

Rev 08-10-98