

CHI Message History Report

Date: _____

Referred By: _____

Name: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Home Phone:(____) ____ - _____ Cell:(____) ____ - _____ Work(____) ____ - _____

E-mail: _____

Emergency Contact: _____ Phone: (____) ____ - _____

Date of Birth: ____/____/____ Marital Status: Single ____ Separated ____ Divorced ____ Married ____ Widowed ____

SS# _____ Number of Children: _____

Occupation: _____ Employer: _____ Bus. Ph. _____

Reason for Today's Visit: _____

Any Surgeries or Hospitalization Yes___ No___ If Yes state what & when _____

Any Accidents Yes___ No___ If Yes state when _____

Any Immune Problems Yes___ No___ If Yes state what _____

What is your dominant emotion? _____ What is your sleeping trend? _____

How many Bowel movements do you have per day? _____ What is their consistency? _____

How many ounces of pure water do you consume per day? _____

Do you wear contacts or other prosthesis? _____

Have you ever received a massage before? _____

Types of massage experienced before: Deep Tissue___ Swedish___ Other___

Date of Last (Approx.)	Frequency				
	None	Light	Moderate	Heavy	
_____ Physical Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
_____ Blood Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea
_____ Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco
_____ Spinal X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drugs
_____ Dental X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise
_____ Urine Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft Drinks

Have you Ever:

- Been Knocked Unconscious
- Used a Crutch or Other Support
- Been Treated for a Spine or Nerve Disorder
- Had a Fractured Bone
- Been Hospitalized other than for Surgery

*Please list any allergies or prescription drugs now taking _____

**CHECK the following conditions YOU have now or have had:
CIRCLE all items that are common to other family members**

- | | | | | | |
|---|--------------------------------------|--|---|--|---|
| <input type="checkbox"/> AIDS-HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Food Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures |

Have you ever experienced problems with:

- | <u>Yes</u> | <u>No</u> | <u>Yes</u> | <u>No</u> | <u>Yes</u> | <u>No</u> | <u>Yes</u> | <u>No</u> |
|--------------------------|--|--------------------------|---------------------------------------|--------------------------|---|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Liver | <input type="checkbox"/> | <input type="checkbox"/> Heart | <input type="checkbox"/> | <input type="checkbox"/> Lungs | <input type="checkbox"/> | <input type="checkbox"/> Kidneys |
| <input type="checkbox"/> | <input type="checkbox"/> Spleen | <input type="checkbox"/> | <input type="checkbox"/> Pancreas | <input type="checkbox"/> | <input type="checkbox"/> Intestines | <input type="checkbox"/> | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> | <input type="checkbox"/> Bladder | <input type="checkbox"/> | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> | <input type="checkbox"/> Uro-genital or Gynecological | | |
| <input type="checkbox"/> | <input type="checkbox"/> Appetite or Digestion | | | | | | |

Please complete other side

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- | | |
|------------------------|--|
| Occasional
Frequent | <p><u>General</u></p> <input type="checkbox"/> <input type="checkbox"/> Allergy
<input type="checkbox"/> <input type="checkbox"/> Convulsions
<input type="checkbox"/> <input type="checkbox"/> Dizziness or Fainting
<input type="checkbox"/> <input type="checkbox"/> Headache
<input type="checkbox"/> <input type="checkbox"/> Neuralgia
<input type="checkbox"/> <input type="checkbox"/> Numbness
<input type="checkbox"/> <input type="checkbox"/> Nervous Tension
<p><u>Muscle & Joint</u></p> <input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Bursitis
<input type="checkbox"/> <input type="checkbox"/> Disk Problems
<input type="checkbox"/> <input type="checkbox"/> Foot Problems
<input type="checkbox"/> <input type="checkbox"/> Low back pain
<input type="checkbox"/> <input type="checkbox"/> Neck pain or stiffness
<input type="checkbox"/> <input type="checkbox"/> Pain between shoulders
<input type="checkbox"/> <input type="checkbox"/> Sciatica
<input type="checkbox"/> <input type="checkbox"/> Sprains
<input type="checkbox"/> <input type="checkbox"/> Swollen Joints
<p><u>Pain, Numbness or Cramps</u></p> <input type="checkbox"/> <input type="checkbox"/> Shoulders
<input type="checkbox"/> <input type="checkbox"/> Arms
<input type="checkbox"/> <input type="checkbox"/> Elbows
<input type="checkbox"/> <input type="checkbox"/> Hands
<input type="checkbox"/> <input type="checkbox"/> Hips
<input type="checkbox"/> <input type="checkbox"/> Legs
<input type="checkbox"/> <input type="checkbox"/> Knees
<input type="checkbox"/> <input type="checkbox"/> Feet
<p><u>Cardio-Vascular</u></p> <input type="checkbox"/> <input type="checkbox"/> Aneurysm
<input type="checkbox"/> <input type="checkbox"/> Hardening of Arteries
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> Pain over Heart
<input type="checkbox"/> <input type="checkbox"/> Phlebitis
<input type="checkbox"/> <input type="checkbox"/> Poor Circulation
<input type="checkbox"/> <input type="checkbox"/> Rapid Heart Beat
<input type="checkbox"/> <input type="checkbox"/> Slow Heart Beat
<input type="checkbox"/> <input type="checkbox"/> Swelling of Ankles
<input type="checkbox"/> <input type="checkbox"/> Thrombosis |
|------------------------|--|

- | | |
|------------------------|---|
| Occasional
Frequent | <p><u>Gastro-Intestinal</u></p> <input type="checkbox"/> <input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> <input type="checkbox"/> Colon Problems
<input type="checkbox"/> <input type="checkbox"/> Constipation
<input type="checkbox"/> <input type="checkbox"/> Diarrhea
<input type="checkbox"/> <input type="checkbox"/> Difficult Digestion
<input type="checkbox"/> <input type="checkbox"/> Distension of Abdomen
<input type="checkbox"/> <input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> <input type="checkbox"/> Hernia
<input type="checkbox"/> <input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> <input type="checkbox"/> Liver Problems
<input type="checkbox"/> <input type="checkbox"/> Pain over Stomach
<input type="checkbox"/> <input type="checkbox"/> Ulcers
<p><u>Eyes, Ears, Nose & Throat</u></p> <input type="checkbox"/> <input type="checkbox"/> Asthma
<input type="checkbox"/> <input type="checkbox"/> Colds
<input type="checkbox"/> <input type="checkbox"/> Deafness
<input type="checkbox"/> <input type="checkbox"/> Earaches
<input type="checkbox"/> <input type="checkbox"/> Ear Discharge
<input type="checkbox"/> <input type="checkbox"/> Ear Noises
<input type="checkbox"/> <input type="checkbox"/> Eye Pain
<input type="checkbox"/> <input type="checkbox"/> Nasal Obstruction
<input type="checkbox"/> <input type="checkbox"/> Nosebleeds
<input type="checkbox"/> <input type="checkbox"/> Sinus Infections
<p><u>Respiratory</u></p> <input type="checkbox"/> <input type="checkbox"/> Chest Pain
<input type="checkbox"/> <input type="checkbox"/> Chronic Cough
<input type="checkbox"/> <input type="checkbox"/> Difficult Breathing
<input type="checkbox"/> <input type="checkbox"/> Spitting up Blood
<input type="checkbox"/> <input type="checkbox"/> Spitting up Phlegm
<input type="checkbox"/> <input type="checkbox"/> Wheezing
<p><u>Skin</u></p> <input type="checkbox"/> <input type="checkbox"/> Bruise Easily
<input type="checkbox"/> <input type="checkbox"/> Dryness
<input type="checkbox"/> <input type="checkbox"/> Infectious Diseases
<input type="checkbox"/> <input type="checkbox"/> Inflammation
<input type="checkbox"/> <input type="checkbox"/> Lymphoma
<input type="checkbox"/> <input type="checkbox"/> Melanoma
<input type="checkbox"/> <input type="checkbox"/> Skin Infections
<input type="checkbox"/> <input type="checkbox"/> Skin Eruptions (rashes)
<input type="checkbox"/> <input type="checkbox"/> Varicose Veins |
|------------------------|---|

- | | |
|------------------------|--|
| Occasional
Frequent | <p><u>Genito-Urinary</u></p> <input type="checkbox"/> <input type="checkbox"/> Bed-wetting
<input type="checkbox"/> <input type="checkbox"/> Blood in Urine
<input type="checkbox"/> <input type="checkbox"/> Frequent urination
<input type="checkbox"/> <input type="checkbox"/> Inability to control bladder
<input type="checkbox"/> <input type="checkbox"/> Kidney Infections or Stones
<input type="checkbox"/> <input type="checkbox"/> Painful Urination
<input type="checkbox"/> <input type="checkbox"/> Prostate Problems
<input type="checkbox"/> <input type="checkbox"/> Pus in Urine |
|------------------------|--|

Occasional Frequent	<p><u>For Women Only</u></p> <input type="checkbox"/> <input type="checkbox"/> Congested Breasts <input type="checkbox"/> <input type="checkbox"/> Cramps or Backache <input type="checkbox"/> <input type="checkbox"/> Excessive Menstrual Flow <input type="checkbox"/> <input type="checkbox"/> Moderate Menstrual Flow <input type="checkbox"/> <input type="checkbox"/> Hot Flashes <input type="checkbox"/> <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> <input type="checkbox"/> Lumps in Breasts <input type="checkbox"/> <input type="checkbox"/> Menopausal Symptoms <input type="checkbox"/> <input type="checkbox"/> Painful Menstruation <input type="checkbox"/> <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No Birth Control Pills <input type="checkbox"/> Yes <input type="checkbox"/> No Breasts Augmentation <input type="checkbox"/> Yes <input type="checkbox"/> No IUD Control Device <input type="checkbox"/> Yes <input type="checkbox"/> No Previous Miscarriages Date of Last Cycle _____
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Medical Doctor: _____ Phone #: _____

Last Office Visit: _____

After reading and filling out your case history, your signature will verify that all the information you have given is accurate and that you have read the case history questions entirely.
 I hereby give permission to the doctors to release any information requested by my insurance company acquired in the course of my examination and treatment.
 Our policy requires payment in full for all services rendered at the time of visit.

I am responsible for paying for any appointment cancellation of less than 12 hours.

Sign your name: _____ Date: _____