Altruistic
THERAPY SERVICES

124 S. State Rd.
Davison MI 48423

ADULT CASE HISTORY FORM:

Name: _____ **Date of birth**: _____

Address:_____

Cell:_____ **Home**:_____

Date of injury, accident or incident:_____

Emergency Contact:_____**Phone:**_____

Occupation_____

Primary care physician: _____

Referring physician: _____

Person filling out this form (circle one): self_____ other: _____

Are you seeking services for: (check which one applies)

Speech / language services _____
Massage services:_____

Medical history: please be specific and circle all that apply. Please provide the dates where applicable.

Acid reflux
Anxiety
Arthritis
Artery / vein problems
Artificial joints / limbs
Asthma
Automobile Accident
Date:_____
Back / spinal conditions
Blood Clots
Broken bones
Bronchitis
Bruises easily
Cancer
Cerebral palsy
Chronic colds
Chronic Fatigue
Chronic laryngitis
Cleft palate
Cold hands / feet
Constipation / Diarrhea
Contagious Disease
COPD
Decreased Range of Motion
Dentures
Diabetes
Disease
Dizziness
Drug / Alcohol/ Tobacco use
Ear infections
Edema
Emotional or psychological
Epilepsy
Facial nerve palsy
Fatigue
Fever
Fibromyalgia
Head/neck cancer
Head injury
Hearing loss
Heart attack
Heart troubles
HIV
Huntington's or Parkinson's
Hypertension
Hypoglycemia
Insomnia / sleep disturbances
Intellectual deficits
Intubation / Vent
Joint pain / stiffness
Kidney / bladder
Loss of sensation
Where?_____
Meningitis
MRSA
Multiple sclerosis
Nerve Disorder
Neuralgia
Neurological conditions
Numbness / Tingling
Osteoporosis
Pacemaker
PMS / Menopause
Pneumonia
Pregnancy
Rash
Respiratory Problems
Seizures
Shingles
Sinusitis / Sinus Problems
Stress / Tension
Stroke
Thyroid issues

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TMJ	Visible skin irritants
Tracheostomy	Vocal polyps or nodules
Tuberculosis	Voice issues or changes
Varicose Veins	Whiplash Injury

Please list any additional medical issues not listed above: _____

_____

Allergies:
Please include food, environmental, skin and chemical allergies:

_____

_____

_____

_____

Are you sensitive to lotions or oils? YES / NO
If yes, please list:

_____

_____

Are you allergic or sensitive to latex? YES / NO

What is your current state of health?

☐ Excellent
☐ Average-fair
☐ Poor

How active are you and what physical activities are you routinely involved in and what limitiations have occurred as a result of your medical condition or accident?

Why were you referred to our clinic?

_____

_____

_____

Have you been hospitalized as a result of your diagnosis or injury? If so, where, when and please provided any specifics regarding you diagnosis and any additional medical complexities.

What is the date of your accident or injury and briefly describe what happen_____

_____

_____

Briefly list any surgeries you have undergone related to you current medical condition or accident and month, day and year.

_____

_____

_____

_____

_____

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Please list **ALL** supplement and medications you are taking at this time:
Include dosage and how many times per day.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you use any of the following assistance devices?

☐ Wheelchair ☐ Cane ☐ None
☐ Walker ☐ Other

Are you able to climb stairs? _____Yes _____No

SOCIAL AND EDUCATIONAL HISTORY

1. Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed

2. Spouse or partner's name: _____

3. Children:

Name	Age

4. Occupation: _____

Do you currently work? _____YES _____NO

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5. Employer: _____

6. Highest level of education (grade or degree) completed. _____

Please provide other information you believe to be helpful in the development of your care.

PLEASE FILL OUT ONLY IF YOU ARE GOING TO RECEIVE MASSAGE THERAPY FROM ALTRUISTIC OTHERWISE SKIP THIS SECTION:

MASSAGE THERAPY HISTORY:

Have you ever had a massage before?

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of? **Yes_____ No_____**

_____

_____

Please circle areas which are currently causing you symptoms of pain, stiffness, numbness or other forms of discomfort and **indicate if left, right or bilateral (both sides)**

Face
Upper back
Arm(s)
Hand(s)
Thigh(s)
Ankle(s)
Neck
Mid back
Elbow(s)
Finger(s)
Knee(s)
Feet
Shoulder(s)
Lower back
Wrist(s)
Head
Hip(s)
Leg(s)
Toe(s)
Chest
Ribs
Tailbone

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

_____
_____
_____
_____
_____

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PLEASE FILL OUT ONLY IF YOU ARE GOING TO RECEIVE SPEECH SERVICES. OTHERWISE SKIP THIS SECTION

SPEECH-LANGUAGE-SWALLOWING-COGNITIVE HISTORY

Symptom	Never	Sometimes	Frequently
Difficulty chewing			
Difficulty swallowing			
Difficulty expressing thoughts			
Difficulty being understood by others, slurred speech and poor breath support/ shortness of breath while speaking			
Difficulty understanding what others are saying to you			
Orientation / memory / sequencing / organizing/processing			
Difficulty with planning out Activities of Daily Living			
Problem solving			
Focusing / attention			
Reading / writing			
Finding words			
Maintaining topic of conversation			
Fluent speech (stuttering)			
Following directions			
Oral motor weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc.)			
Voice difficulties			

If swallowing difficulties what form of nutritional intake and what food consistencies?
(For example: Puree, mechanical soft, solids, thins, nectar thick, honey thick, PEG tube feed)

Are there any other difficulties besides what is listed above?

When was this problem first noticed?

Please rate your pain from a scale of 1-10 (1 being minimal pain and 10 being severe pain) _____

Please describe what circumstances exacerbate your condition._____
_____

Please describe in detail how your pain (if any), affects your daily function, physical, emotional and overall mental well-being?_____

Please describe in detail how your speech, language, cognitive, swallow difficulties (if any), affect your daily function, physical, emotional and mental well-being._____
_____

I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge and understand that the Massage Therapist and / or Speech Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Altruistic Therapy Services, LLC and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Therapist updated on my medical history and medical appointments related to the case. The information I have provided is true and complete to the best of my knowledge.

_____ _____
Patient/Agent/Guardian/Representative signature Date