Health History Form

For your information:

An accurate health history is important to ensure that it is safe for you to receive massage therapy. If your health status changes, Let your massage Therapist know as soon as possible and this form will be updated. All information gathered for this treatment is confidential except as required or allowed by law, or to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

TODAY'S DATE: _____
LAST NAME:_____FIRST NAME:_____
BIRTHDAY: M_____ D_____ Y_____ AGE: _____ GENDER: M F
ADDRESS:_____
_____
OCCUPATION:_____
PHONE #:_____WORK PHONE #:_____
CELL PHONE #:_____

EMAIL:_____

HOW DID YOU HEAR ABOUT US / WHO REFFERD YOU? _____

HAVE YOU RECEIVED MASSAGE THERAPY BEFORE? YES NO

Please indicate conditions you are experiencing with a √ or have experienced with a x:

Respiratory ☐ chronic cough ☐ shortness of breath ☐ bronchitis ☐ asthma ☐ emphysema ☐ Family history of the above?_____ **Cardiovascular** ☐ high blood pressure ☐ low blood pressure ☐ chronic/congestive heart failure ☐ heart attack ☐ heart disease ☐ phlebitis ☐ stroke/CVA ☐ pacemaker or similar device ☐ Family history of the above?_____ **Skin** ☐ skin irritations/conditions	**Infections** ☐ hepatitis ☐ tuberculosis ☐ HIV ☐ Other:_____ **Other Conditions** ☐ loss of sensation location:_____ ☐ allergies type:_____ ☐ diabetes type:_____ onset:_____ ☐ epilepsy ☐ cancer type:_____ location:_____ ☐ arthritis type:_____ location:_____ ☐ fibromyalgia ☐ chronic fatigue syndrome ☐ depression ☐ anxiety	**Soft tissue/joint discomfort** ☐ neck ☐ upper back ☐ mid back ☐ low back ☐ shoulders ☐ arms ☐ hands ☐ legs ☐ knees ☐ feet ☐ other_____ **Head/Neck** ☐ vision problems ☐ vision loss ☐ hearing problems ☐ hearing loss **Women** ☐ pregnant due date:_____ ☐ gynecological conditions ifany? _____ ☐ # of children_____

Health and Medical History (Continued)

Yes No
☐ ☐ Are you taking any medications? List **medication name and <u>what you are taking it for</u>**:

_____
_____ _____
_____
_____
_____
_____

Yes No
☐ ☐ In the past, have you taken medications? List medication name and what you were taking it for:

_____
_____
_____

Please list any hospitalizations and surgeries you have had (including the date):

_____
_____
_____

Yes No
☐ ☐ Have you had any recent or significant falls or trauma? Date and description for each:

_____
_____
_____
_____

Yes No
☐ ☐ Have you ever been in a motor vehicle collision? Date and describe:

_____
_____
_____

Yes No
☐ ☐ Have you had any other trauma or injuries?

_____
_____
_____

Other medical conditions (e.g. Digestive conditions, hemophilia, etc.)

_____
_____
_____

Of special note (presence of internal pins, wires, artificial joints, special equipment):

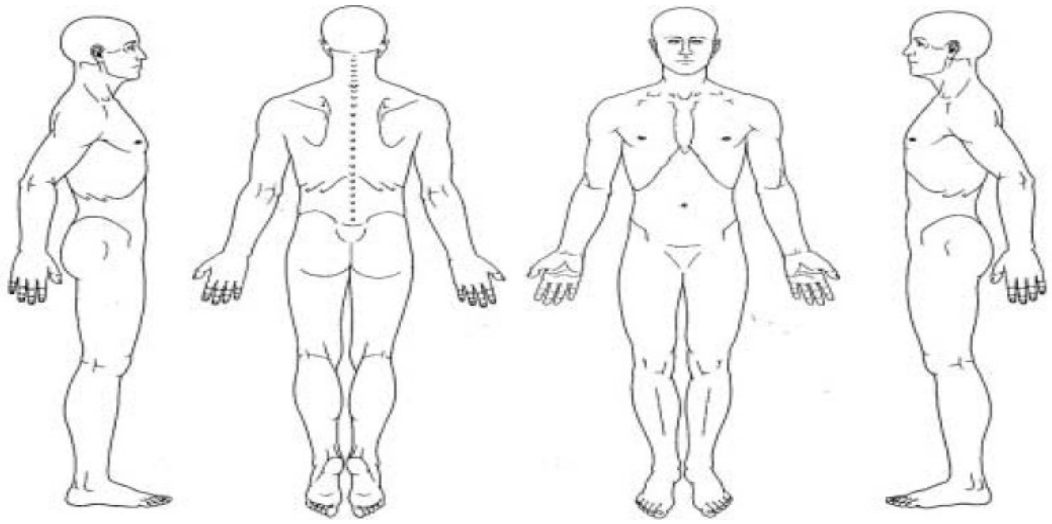
_____
_____
_____

What is your general health status? _____

Primary Complaint

What brings you into our office today?_____

Please indicate the area of complaint:



Describe your pain/symptom (sharp, dull, ache, numbness, tingling, burning, tightness, other):
_____

When did it start? _____

Does the pain radiate? Describe:
_____
_____

What caused the problem? How did it happen?
_____
_____
_____

Grade the intensity of your symptom/pain on a scale of 1 to 10 (10 being the worse pain you can imagine):
_____
1 5 10

When does your pain/symptom occur? (all day / in the AM / at night / daily / once a week, etc.):
_____

Describe the pattern of your symptom/pain (continuous, intermittent, worsens during the day, etc.):
_____

Describe the duration of your symptoms (seconds, minutes, hours, days, etc.)_____

What makes it feel better?_____

What makes it feel worse? _____

Are there any other related pains or symptoms? _____

Have you done anything about it so far? Did it work?

_____
_____

Has this problem (or something similar) occurred before, or is this the first time?

_____
_____

What did you do about it then? Did it help?

_____
_____

Do you have any other complaints or concerns you want us to know about? Please describe:

_____
_____
_____

NOTES

_____
_____
_____
_____
_____
_____

Client Signature **Date**

_____

Health History Update #1
Client Signature **Date**

_____

Health History Update #3
Client Signature **Date**

_____