Health History

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL PH: _____ ALT PH: _____

DOB: _____ EMAIL: _____

OCCUPATION: _____ EMPLOYER: _____

REFERRED BY: _____

EMERGENCY CONTACT: _____ PHONE: _____

FIRST PROFESSIONAL MASSAGE: (Y/N) _____ IF YES, HOW FREQUENT: _____

LIST INJURIES, HOSPITALIZATIONS, AND SURGERIES: WHEN THEY OCCURRED AND TREATMENT RECEIVED:

_____

_____

ANY LINGERING EFFECTS FROM THE ABOVE: _____

CHRONIC PAIN: (Y/N) _____ IF YES, DESCRIBE: _____

PAIN WITH DAILY ACTIVITIES: (Y/N) _____ IF YES, WHAT ACTIVITIES AND WHERE IS THE PAIN: _____

_____

OTHER FORMS OF CARE YOU ARE RECEIVING AND FOR WHAT: _____

_____

CURRENTLY TAKING PRESCRIBED DRUGS: (Y/N) _____ IF YES, DESCRIBE: _____

_____

DAILY EXERCISE AND/OR STRETCHING REGIME: (Y/N) _____ IF YES, DESCRIBE: _____

_____

OVER THE COUNTER DRUGS, SUPPLEMENTS AND/OR HERBS TAKEN: (Y/N) _____

IF YES, WHAT AND WHY: _____

HISTORY: MARK ALL THAT APPLY, PAST (P) OR CURRENT (C)

____ OSTEOPOROSIS
____ ARTHRITIS
____ HYPOTHYROIDISM
____ CHRONIC FATIGUE
____ GOUT
____ BURSITIS
____ PLANTAR FASCIITIS
____ CYSTS/LIPOMAS
____ TMJ
____ HEADACHES
____ TENDONITIS
____ WHIPLASH
____ PNEUMONIA
____ ASTHMA
____ BREATHING PROBLEMS
____ SINUSITIS
____ ULCERS
____ COLITIS
____ IBS
____ CROHN'S DISEASE
____ GLUTEN INTOLERANCE
____ CONSTIPATION
____ DIARRHEA
____ GALLSTONES

____ GAS/BLOATING
____ CHRONIC INDIGESTION
____ HEART PROBLEMS
____ STROKE
____ PALPITATIONS
____ MITRAL VALVE PROLAPSE
____ ANEMIA
____ HEMOPHILIA
____ LOW BLOOD PRESSURE
____ PERIPHERAL ARTERY DISEASE
____ RAYNAUD'S DISEASE
____ VARICOSE VEINS
____ BLOOD CLOTS/PHLEBITIS
____ FUNGAL INFECTIONS
____ ATHLETE'S FOOT
____ IMPETIGO
____ ECZEMA/DERMATITIS
____ PSORIASIS
____ EASILY IRRITATED SKIN
____ DIZZINESS
____ ALS
____ MULTIPLE SCLEROSIS
____ PARKINSON'S DISEASE
____ BELL'S PALSY

____ NEURITIS
____ SPINAL CORD INJURY
____ TRIGEMINAL NEURALGIA
____ SEIZURES/EPILEPSY
____ DIABETES
____ PREGNANCY
____ CANCER
____ KIDNEY DISEASE
____ HEPATITIS
____ HIV/AIDS
____ LUPUS
____ POSTOPERATIVE
____ CYSTITIS
____ HIGH STRESS
____ GRIEVING
____ ANXIETY/PANIC ATTACKS
____ BIPOLAR SYNDROME
____ PMS/MENOPAUSE DIFFICULTIES
____ POOR SLEEP/INSOMNIA
____ ALLERGIES
____ ORTHOPEDIC PINS OR PLATES
____ OTHER: _____

IF NECESSARY, EXPLAIN ABOVE: _____

_____

THE ABOVE INFORMATION IS ACCURATE. I UNDERSTAND THAT MASSAGE THERAPISTS DO NOT DIAGNOSE DISEASE OR PRESCRIBE DRUGS AND THAT THEY ARE NOT A SUBSTITUTE FOR MEDICAL CARE. I AGREE TO ALERT MY PRACTITIONER OF ANY PHYSICAL/EMOTIONAL CHANGES AS THEY OCCUR. I ALSO UNDERSTAND THAT A MISSED APPOINTMENT WILL RESULT IN A 50% CHARGE OF ORIGINIAL SERVICE FEE.

SIGNATURE: _____ DATE: _____