~~~~~~~~~~~~~~~~~~~~~~ HEALTH HISTORY ~~~~~~~~~~~~~~~~~~~~~~

PATIENT INFORMATION

DATE ____________________________

NAME ____

DATE OF BIRTH ___________________

ADDRESS ____
____

PHONE (H) ________________________
(W) ________________________
(C) ________________________

OCCUPATION ____________________________________

ARE YOU PRESENTLY UNDER A DOCTOR'S OR THERAPIST'S CARE? ❑ YES ❑ NO
IF SO, FOR WHAT CONDITION? ____

HAVE YOU EVER HAD A PROFESSIONAL MASSAGE OR OTHER TYPE OF BODYWORK? ❑ YES ❑ NO
IF SO, WHAT KIND(S) ____

WHAT DO YOU HOPE TO GAIN FROM THE BODY WORK? ____

MEDICAL CONDITIONS - CHECK ANY MEDICAL CONDITIONS (PAST OR CURENT). NOTE ANY AILMENT NOT LISTED, INCLUDING RECENT RASHES, BRUISES, BUMPS, BREAKS, SPRAINS, STRAINS, FRACTURES, OR ILLNESSES. THE PARTIAL LIST THAT FOLLOWS IS NOT MEANT TO BE ALL INCLUSIVE.

❑ Abscess/open sore/surgical site
❑ Allergies
❑ Arteriosclerosis
❑ Asthma
❑ Blood clot
❑ Bunions
❑ Cancer/malignancy
TYPE _____________
DIAGNOSED ________
LAST TREATMENT _____
❑ Carpal Tunnel Syndrome
❑ Cerebral Palsey
❑ Charcot Foot
❑ Chronic fatigue syndrome
❑ Chronic pain (where?)
____
❑ Cold or flu
❑ Depression
❑ Deep vein thrombosis

❑ Diabetes
❑ Digestive problems
❑ Disc (ruptured or bulged?)
❑ Easy bruising
❑ Epilepsy
❑ Fibromyalgia
❑ Fibrositis
❑ Fluid Retention
❑ Fractures/breaks/bone injury
❑ Frozen shoulder
❑ Hammer toe
❑ Headaches
❑ Heart disease
❑ Herniated disc
❑ Hepatitis
❑ Herpes I or II
❑ Hip injury
❑ History of mental illness, physical or emotional abuse, counseling/ therapy

❑ HIV/AIDS
DIAGNOSED ________
LAST TREATMENT _____
❑ Hypermobility syndrome
❑ Hypertension
❑ Implants
where? __________
❑ Infection
❑ Inner ear problems
❑ Insomnia
❑ Joint injury
❑ Knee injury
❑ Neuroma
❑ Osteoarthritis
❑ Osteoporosis
❑ Parkinsons
❑ Peripheral Neuropathy
❑ Phlebitis

❑ PMS/problem cycle
❑ Poor circulation
❑ Pregnant
❑ Recent surgery
❑ Rheumatoid arthritis
❑ Rotator cuff
❑ Shortness of breath
❑ Skin sensitivity
❑ Spinal cord injury
❑ Stomach ulcers
❑ Stroke
❑ Taking medication
❑ Thoracic Outlet Syndrome
❑ Unsuccessful surgery
❑ Varicose veins
❑ Whiplash
❑ Any genetic defects

Other conditions not listed or past injuries that still affect you: ____

Name of Health Care Provider: ________________________________Phone: ____________________

If necessary, do I have permission to contact your health care provider? ❑ YES ❑ NO

LIFE STYLE

Do you exercise? ❑ YES ❑ NO How often? _______________ What type? _______________

Do you use Tobacco? ❑ YES ❑ NO
Alcohol? ❑ YES ❑ NO
Caffeine? ❑ YES ❑ NO

Any nutritional/eating concerns? ____

On a scale of 0 to 10 (highest), what is your stress level today? 1 2 3 4 5 6 7 8 9 10

…what is your pain level today? 1 2 3 4 5 6 7 8 9 10

Is there any area of the body where you seem to hold a lot of tension? ______________________________

I understand that massage practitioners are not trained in the diagnosis and treatment of diseases. I confirm that I have consulted a medical doctor for all the conditions checked and have received authorization to have BODYWORK. By signing this release, I do hereby waive and release the massage practitioner from all liability, past, present, and future.

SIGNATURE ____ DATE ________________________

*If you have any concerns, please feel free to inquire about them.