Patient Information and Health History

Name____ Date____________________
Occupation_____________________________ Date of Birth______________________
Mailing Address____
City_____________________________ State _________ Zip______________________
Phone ___________________________ Email __________________________________
Emergency Contact ______________________ Phone___________________________

Are you currently under a Physician's care? ____ What for? __________________
____
Current Medications (prescribed/over the counter medications, alcohol, herbs, and supplements) ____
____
Daily Activities____
____
What do you do to relieve stress? ____
Have you received massage before? ______ When? ___________________________
What are your current goals for massage? __________________________________
____

Health concerns for focus during treatment (check all that apply):

Concern____
Severity: mild____ moderate ____ severe____
Frequency: constant ____ intermittent ____
Symptoms: increase with activity____ decrease with activity ____
Changes: getting better____ getting worse____ no change____
Treatment received____
Activities Limited by condition____
Comments____

Concern____
Severity: mild____ moderate ____ severe____
Frequency: constant ____ intermittent ____
Symptoms: increase with activity____ decrease with activity ____
Changes: getting better____ getting worse____ no change____
Treatment received____
Activities Limited by condition____
Comments____

Health History (please provide information for past and present conditions including dates)
Surgeries____
____
Major illnesses ____
____

Injuries____

____

Health Conditions (please **circle current** and **underline previous** conditions; also include relevant dates)

	Comments:
General	
Pain Numbness Altered Sensation	___________________________________
Headaches Fatigue Sleep Disturbance	___________________________________
Infection Swelling Allergies Other	___________________________________
Musculoskeletal	
Arthritis Osteoporosis Scoliosis	___________________________________
Fracture Sprain Strain Bursitis	___________________________________
Disc Problems TMJD Tendonitis	
Stiffness Other	
Cardiovascular/Respiratory	
Anemia Angina Arteriosclerosis	___________________________________
Congestive Heart Failure Heart Attack	___________________________________
Heart Disease Hypertension Blood Clots	___________________________________
Irregular Heart Beat Varicose Veins	___________________________________
Phlebitis Asthma Other	___________________________________
Nervous	
Concussion Head Injury Stroke	___________________________________
Anxiety Depression Other	___________________________________
Endocrine	
Diabetes Thyroid Other	___________________________________
Integumentary	
Abrasion/cut Rash Other	___________________________________
Reproductive/Urinary	
Pregnancy Endometriosis	___________________________________
Hysterectomy Other	___________________________________
Immune	
Autoimmune Disease Other	___________________________________
Digestion and Elimination	
Heart Burn Gastric Reflux Ulcer	___________________________________
Bowel problems Gas/Bloating	___________________________________
Urinary Tract Problems Other	___________________________________
Cancer or Tumors	
Benign Malignant	___________________________________

I verify that all of the information provided is correct and current to the best of my knowledge:

Name ______________________ Signature ________________ Date _______