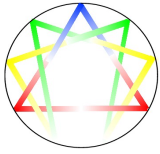

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HEALTH FORM

Your answers to the following questions will be kept confidential. They will be seen only by me and are requested so that I may provide you with better care.

Name____ Date____________________

Address____ Phone(day)________________

City________________________ State_____ Zip________ Phone(eve)________________

Age___ D.O.B.____/____/____ Sex___ Pregnant?____ E-Mail Address ____________________

Occupation_______________________ What do you do for exercise?______________________

For relaxation?__________________________ Have you received previous massage work? __________

Reason(s) for coming for massage now: ____

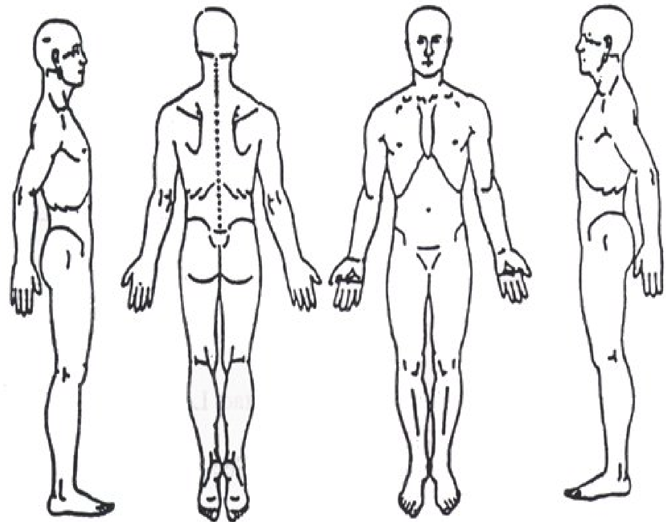
Any specific areas you would like worked on? _______________________________________

Any major traumas you have had to your body (e.g. accident, fall, etc.). Please include ALL muscle, bone or joint injuries even if not recent:

____

____

____



You may use the chart to indicate areas of discomfort or desired areas to work on.>

Allergies?_________________________

Drugs(prescription/recreational)? _________

____

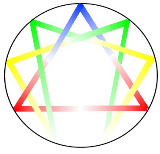
Is there anything else I should know? ____

____

The following sometimes occur during massage. They are normal responses to relaxation and/or touch, and you need not be embarrassed nor suppress them. Movement or release of intestinal gas, crying, laughing, strong emotions, sighing, groaning, yawning, softening of muscle tissue, cognitive or felt memories, stomach gurgling, need to move or change position. At any time during your session please let me know if there is anything I can do to help you feel more comfortable.

I understand that the services provided are not a replacement for medical or psychological care and that any information provided is not prescriptive or diagnostic in nature and is for educational purposes only. I also give my permission for the CMT(s) with whom I work to discuss information pertinent to my condition(s) and treatment, with my other health care providers.

Client's Signature____ Date ____/____/____



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CLIENT HEALTH INFORMATION SHEET

Name: ______________________________ Date: ______________

Present symptoms: What is your major complaint or condition you want to improve? ______________

____

When did you first notice major complaints? ______________________________

What brought it on? ______________________________

____

What activities aggravate the condition? ______________________________

____

Is this condition getting worse? • Y • N Please Explain: ______________________________

Does this condition interfere with work? • Y • N Sleep? • Y • N Daily Routine? • Y • N

Please Explain: ______________________________

What have you done to get relief? ______________________________

____

Has there been a medical diagnosis? • Y • N If so, by whom? ______________________________

Please Explain: ______________________________

____

Have you had X-rays taken? • Y • N

If yes, by whom? ______________________________

What are your intentions or expectations for this visit? ______________________________

____

____

Are you now under medical/therapeutic treatment? • Y • N

If yes, for what condition? ______________________________

____

____

Please list your care provider's name and phone number: ______________________________

____

List any medications (including aspirin) and nutritional supplements you are taking: ______________

____

Describe the exercise activities you do (include frequency): ______________________________

____

List other therapies you receive: ______________________________

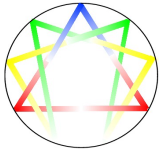
____

Please list (date and description) any accidents or operations: ______________________________

____

Please list any additional comments regarding your health and well-being: ______________________________

____



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HEALTH HISTORY

Check the following conditions that apply to you, past and present. Please add any clarifying comments.

Musculo-Skeletal
- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: ____________________

Circulatory and Respiratory
- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: ____________________

Skin
- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic surgery
- Other: ____________________

Digestive
- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other: ____________________

Nervous System
- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Other: ____________________

Reproductive System
- Pregnancy:
  - Current
  - Previous
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostrate problems

Other
- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Drug use __________________
- Alcohol use _______________
- Nicotine use _______________
- Caffeine use _______________
- Hearing impaired
- Visually impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious disease (please list) ____________________________
- Other congenital or acquired disabilities (please list) _______ ____________________________
- Surgeries _________________
- Other: ____________________

For clients who need mobility assistance, please give your height: _______ weight: _______

Please list any additional comments regarding your health and well-being: ____

____

I have stated all conditions and this information is true and accurate. I will inform the therapist of any changes in my status.

Client's Signature: ____ Date:________________