Client Health History

GENERAL INFORMATION

Name:		Home Phone:
Address:		
City:	State:	Zip Code:
Date of Birth:	Gender/Gender Identification:	
Pronouns:		
Email:		
Employer:	Work/Cell:	
Emergency Contact:		Phone:
Spouse/Significant Other:		Phone:
Referred By:		Phone:

CURRENT HEALTH

What is your primary complaint?

List and prioritize your current symptoms/issues *(stress, pain, stiffness, numbness/tingling, swelling, etc.)*

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)?

☐ Yes ☐ No

Explain:

Are you currently taking any medication?

☐ Yes ☐ No

If yes, what are you taking and why?

CURRENT HEALTH *(cont.)*

Are you involved in any other therapy at this time (chiropractic care, physical therapy, talk therapy, etc.)?

☐ Yes ☐ No

If yes, what therapy and how often?

Is your current injury a result of an accident?

☐ Yes ☐ No Date of accident:

Please list any previous injuries such as broken bones, severe sprains, strains, whiplash, traumas, auto accidents, surgeries, medical conditions, etc. Give dates if necessary.

Do you exercise regularly and/or participate in any sports?

☐ Yes ☐ No

If yes, what kind?

Do you perform any repetitive movement in your work, sports, or hobby?

☐ Yes ☐ No

If yes, describe:

Do you sit for long hours at a workstation, computer, or driving?

☐ Yes ☐ No

If yes, describe:

Do you experience stress at work or in your personal life?

☐ Yes ☐ No

If yes, describe:

MASSAGE INFORMATION

Have you ever received professional massage/body work before?

☐ Yes ☐ No

How recently?

What are your goals/expected outcomes for receiving massage/bodywork?

HEALTH HISTORY

Do you have or have you had any of the following conditions?

Musculoskeletal

Current	Past	
☐	☐	Bone or Joint Disease
☐	☐	Arthritis / Rheumatoid Arthritis / Gout
☐	☐	Lupus
☐	☐	Migraines / Headaches
☐	☐	Tendonitis / Bursitis
☐	☐	Jaw Pain (TMJ)
☐	☐	Spinal Problems
☐	☐	Osteoporosis/Degenerative Disk
☐	☐	Scoliosis
☐	☐	Muscle or Joint Pain
☐	☐	Muscle or Joint Stiffness
☐	☐	Broken Bones

Circulatory

Current	Past	
☐	☐	Heart Condition
☐	☐	Blood Clots
☐	☐	Lymphedema
☐	☐	Phlebitis / Varicose Veins
☐	☐	High / Low Blood Pressure
☐	☐	Thrombosis / Embolism
☐	☐	Swelling

Respiratory

☐	☐	Breathing Difficulty / Asthma
☐	☐	Emphysema
☐	☐	Sinus Problems
☐	☐	Allergies

Please specify any allergies:

HEALTH HISTORY *(cont.)*

Nervous System

Current	Past	
☐	☐	Shingles
☐	☐	Pinched Nerve
☐	☐	Paralysis
☐	☐	Parkinson's Disease
☐	☐	Numbness / Tingling
☐	☐	Chronic Pain
☐	☐	Multiple Sclerosis
☐	☐	Epilepsy / Seizures

Head/Neck

Current	Past	
☐	☐	Headaches / Migraines
☐	☐	Ringing in Ears (Tinnitus)
☐	☐	Vision Problems
☐	☐	Concussion
☐	☐	Vertigo / Dizziness
☐	☐	Hearing Loss
☐	☐	Vision Loss
☐	☐	Memory Loss

Digestive

Current	Past	
☐	☐	Irritable Bowel Syndrome
☐	☐	Colitis
☐	☐	Ulcers
☐	☐	Bladder / Kidney Ailment
☐	☐	Crohn's Disease
☐	☐	Gas / Bloating
☐	☐	Constipation

Skin

Current	Past	
☐	☐	Cosmetic Surgery
☐	☐	Herpes / Cold Sores
☐	☐	Rashes / Eczema
☐	☐	Athlete's Foot
☐	☐	Bruise Easily
☐	☐	Allergies

Please list allergies on the page above.

Reproductive

Current	Past	
☐	☐	Ovarian / Menstrual Problems
☐	☐	Prostate Issues
☐	☐	Pregnant

Psychological

Current	Past	
☐	☐	Anxiety / Stress / PTSD
☐	☐	Depression
☐	☐	Easily Overwhelmed

Trauma

Current	Past	
☐	☐	Domestic Violence
☐	☐	Sexual Assault
☐	☐	Childhood Trauma
☐	☐	Car Accident(s)
☐	☐	Surgery
☐	☐	Sensitive to Touch / Pressure
☐	☐	Other *(please specify below)*

Other

Current	Past	
☐	☐	Cancer / Tumors
☐	☐	Drug / Alcohol / Tobacco Use
☐	☐	Dentures
☐	☐	Diabetes
☐	☐	Contact Lenses
☐	☐	Hearing Aids
☐	☐	Other medical conditions not listed:

Please explain any of the conditions that you have marked above:

CONSENT FOR TREATMENT

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension, and rehabilitation. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapists/bodyworkers are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such.

Because massage/bodywork is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment for the "full" schedule appointment.

By signing or typing your name below, you agree to the terms of this agreement.

Patient Signature: ____ Date: ____________________