

Health Information

Client Name _____ Date _____

Client Information

Address _____

City _____ State _____ Zip _____

Phone _____ Alternate _____

Occupation _____

Date of Birth _____

Emergency Contact _____

Phone _____

Current Health Information Check all that apply.

Primary Symptom _____

mild constant getting worse

moderate intermittent getting better

disabling no change

symptoms ↑ w/ activity

symptoms ↓ w/ activity

Treatment received _____

Secondary Symptom _____

mild constant getting worse

moderate intermittent getting better

disabling no change

symptoms ↑ w/ activity

symptoms ↓ w/ activity

Treatment received _____

Additional Symptoms _____

mild constant getting worse

moderate intermittent getting better

disabling no change

symptoms ↑ w/ activity

symptoms ↓ w/ activity

Treatment received _____

Additional Symptom _____

mild constant getting worse

moderate intermittent getting better

disabling no change

symptoms ↑ w/ activity

symptoms ↓ w/ activity

Treatment received _____

List Daily Activities Limited by Conditions

Work _____

Home/Family _____

Sleep/Self-Care _____

Social/Recreational _____

List Self-Care Routines

How do you reduce stress? _____

How do you reduce pain? _____

List current medications (include pain relievers and herbal remedies) _____

Have you ever received a massage? _____

How long ago? _____

Health History

List and explain; include dates and treatment received.

Surgeries _____

Injuries _____

Major Illness _____

Health Information

General

- | | | |
|--------------------------|--------------------------|-------------------------|
| current | past | |
| <input type="checkbox"/> | <input type="checkbox"/> | headache _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | pain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | sleep disturbance _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | fatigue _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | infections _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | fever _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | sinus _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____ |

Skin Conditions

- | | | |
|--------------------------|--------------------------|-----------------------------|
| current | past | |
| <input type="checkbox"/> | <input type="checkbox"/> | rashes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | athlete's foot, warts _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____ |

Muscle and Joints

- | | | |
|--------------------------|--------------------------|--------------------------------|
| current | past | |
| <input type="checkbox"/> | <input type="checkbox"/> | rheumatoid arthritis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | osteoarthritis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | osteoporosis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | scoliosis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | broken bones _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | spinal problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | disk problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | lupus _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | TMJ, jaw pain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | spasms, cramps _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | sprains, strains _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | tendonitis, bursitis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | stiff, painful joints _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | weak or sore muscles _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | neck, shoulder, arm pain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | low back, hip, leg pain _____ |

Nervous System

- | | | |
|--------------------------|--------------------------|--|
| current | past | |
| <input type="checkbox"/> | <input type="checkbox"/> | head injuries, concussion _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | dizziness, ringing in ears _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | loss of memory, confusion _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | numbness, tingling _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | sciatica, shooting pain down leg _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | chronic pain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | depression _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____ |

Respiratory, Cardiovascular

- | | | |
|--------------------------|--------------------------|---------------------------------------|
| current | past | |
| <input type="checkbox"/> | <input type="checkbox"/> | heart disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | blood clots _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | stroke _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | lymphadema _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | high, low blood pressure _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | poor circulation _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | swollen ankles _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | varicose veins _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | chest pain, shortness of breath _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | asthma _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____ |

Allergies

- | | | |
|--------------------------|--------------------------|-----------------------------|
| current | past | |
| <input type="checkbox"/> | <input type="checkbox"/> | scents, oils, lotions _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | detergents _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | rubbing alcohol _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____ |

Digestive/Elimination System

- | | | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | bowel problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | gas, bloating _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | bladder/kidney/prostrate _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | abdominal pain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____ |

Endocrine System

- | | | |
|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | thyroid _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | diabetes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____ |

Reproductive System

- | | | |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | pregnancy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | painful, emotional menses _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | fibrotic cysts _____ |

Cancer/Tumors

- | | | |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | benign _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | malignant _____ |

Habits

- | | | |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | tobacco _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | alcohol _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | coffee, soda _____ |

Consent for Care

It is my choice to receive massage therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature _____ Date _____