Personal Health History Information

All information herein is strictly confidential.

Name ______________________________ Birthday ____________________________________

Address ______________________________ Phone (day) ____________________________________

City/State/Zip______________________________ Phone (eve) ____________________________________

Email ______________________________ Referred by ____________________________________

Occupation___________________________________ Doctor/Clinic __________________________________

Chiropractor _________________________________

Permission to consult with doctor/clinic? **Please initial:** Yes____ No______

Permission to consult with chiropractor? **Please initial:** Yes ____ No _____

Treatment Information

What is the reason for your visit? Please list any current symptoms.

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Are you currently seeing a medical professional? Yes ____ No _____

If yes, for what reason?

____

____

Have you ever suffered an injury/car accident? Yes _____ No _____

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____

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____

Have you ever had surgery? Yes_____ No _____

If yes, please describe all injuries and include dates, diagnosis, and treatment received.

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____

Are you pregnant? *Due date:* Yes _____ No _____

Do you have diabetes? Yes _____ No _____

Do you have vericose veins? Yes _____ No _____

Have you ever been diagnosed with blood clots? Yes _____ No _____

Have you ever been diagnosed with arthritis? Yes _____ No _____

Do you have any heart/blood pressure problems? Yes _____ No _____

Do you have any digestive problems? Yes _____ No _____

Please describe in further detail any condition answered "yes" above:

____

____

____

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Current symptoms:			**often**	**occasional**	**duration of symptom**
Y	N	headaches	_____	_____	____________________
Y	N	neck pain/stiffness	_____	_____	____________________
Y	N	shoulder pain/restriction	_____	_____	____________________
Y	N	pain between shoulders	_____	_____	____________________
Y	N	back pain	_____	_____	____________________
Y	N	general muscle stiffness/ soreness	_____	_____	____________________
Y	N	numbness/tingling in arm/ hand	_____	_____	____________________
Y	N	sore, stiff/aching hips	_____	_____	____________________
Y	N	nerve pain down legs	_____	_____	____________________
Y	N	restricted motion in any area	_____	_____	____________________
Y	N	foot problems	_____	_____	____________________
Y	N	pain when performing certain motions	_____	_____	____________________
Y	N	other - please describe	_____	_____	____________________

Please use this space if you wish to further explain your symptoms.

____

____

____

Current medications:

____

____

____

Exercise: Activity Frequency

____

____

List any other medical or physical condition that has not been mentioned on this form.
(Please include dates, medications, and treatment received.)

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The massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals. Massage therapy is not a substitute for medical examinations and/or diagnosis. Because the massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. I consent to receive treatment by the massage therapist.

Signature ________________________________ *Date* ____________________