HEALTH HISTORY DOCUMENT

Client Information

Name _____ D.O.B _____

Address _____ Phone #1 _____

City _____ Zip _____ Phone #2 _____

Occupation _____ Email _____

Height _____ Weight _____ Gender _____

Emergency Contact _____

Phone _____ Relationship _____

Physician _____ Phone _____

Personal Health Comments

How do you characterize your overall health and fitness? _____

_____

_____

How do you characterize your energy level? _____

_____

Do you exercise regularly and if so what do you do? _____

_____

_____

_____

How do you characterize your diet? _____

_____

_____

How do you characterize your emotional state? _____

_____

_____

How much water do you drink each day? _____

How would you rate your overall level of stress? Low Medium High Maximum

Health/Medical Information

Please mark any condition(s) for which you have been diagnosed:

AIDS/HIV
Arteriosclerosis
Anemia
Aortic Aneurysm
Arthritis
Baker's Cyst
Boils/Carbuncles
Bursitis
Cancer
Diabetes
Diverticulitis/Diverticulosis
Edema
Embolism/Thrombosis
Encephalitis
Gout Heart Conditions
Hematoma
Hepatitis
Hernia
Herniated Disc
Hyperaesthesia
Hypertension
Lyme Disease
Lymphangitis
Osteoporosis
Parkinson's Disease
Peripheral Neuropathy
Phlebitis
Skin Cancer
Spastic paralysis
Thrombophlebitis
Tuberculosis
Tumors
Varicose Veins

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Acne
Amputation
Ankylosing Spondylitis
Anxiety Disorders
Burns
Carpel Tunnel
Chorea
Cystitis
Dislocations
Decubitis Ulcer
Eczema
Endometriosis
Fibrositis
Fractures
Herpes Zoster
Herpes Simplex
Lupus
Migraines
Multiple Sclerosis
Neuritis
Osteoarthritis
Panniculitis
Poliomyelitis
Prostatic Hyperplasia
Sciatica
Sinusitis
Stroke
Whiplash

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Asthma
Bell's Palsy
Chondromalasia
Chronic Fatigue
Syndrome
Contractures
Dysmenorrea
Fibromyalgia
Insomnia
Myofascial Pain Syndrome
Myositis Ossificans
Neuralgia
Pes Planus
Plantar Fascitis
Psoriasis
Raynaud's Disease
Shin Splints
Tension Headaches
Thoracic Outlet Syndrome
TMJ
Torticollis

Please mark any chronic issues, which you experience:

Blurred vision
Depression
Dry eyes
Eye floaters
Migraines
Bitter taste in mouth
Difficulty with fatty foods
Extreme fatigue
Frequent ankle sprains
Overworked
Poor decision-making
Sprains
Stressed out
Yellow eyes

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Angina
Anxiety
Chatterer (excessive talk)
Heart palpitations
Hysteria
Insomnia
Pale or flushed face
Borborygmus
Circulation problems
Earaches
Eye sty
Muddled thinking
Scapula pain
Shoulder pain

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Carpel tunnel
Dizziness (circulation)
Extreme blood pressure
Fever
Poor circulation
Restlessness
Allergies
Lack of strength

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Bruising
Crave sympathy
Menstrual cramping
Menstrual irregularities
Prolapsed organs
Reproductive issues
Varicosities
Water retention
Belching
Cold sores
Halitosis
Heartburn
Indigestion
Nausea
Lassitude
Poor flexibility
Pulled/sore muscles
Shin splints
Vomiting

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Asthma
Bronchitis
Cough
Grief
Hay fever
Melancholy
Self-righteous
Thumb pain
Constipation
Loose stools
Runny nose
Sinusitis
Skin disease
Skin dry/oily
Tennis elbow

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Chronic cough
Dark circles under eyes
Deafness
Dizziness (inner ear)
Earache (inner ear)
Hair loss
Low back pain
Osteoporosis
Poor memory
Restlessness
Ringing in ears
Sexual dysfunction
Aversion to cold
Compulsive behavior
Epilepsy
Hyperactive
Incontinence
Jealousy
Nervous Restless
Scoliosis
Suspicious

Are you taking any medications? If so please list: _____

_____

_____

_____

_____

Are you or have you been in treatment for any psychological/mental health issue that might be aggravated by you receiving massage therapy? YES NO

Do you wear contacts? YES NO

Do you smoke? YES NO

Do you have any surgical pins, plates, artificial joints, etc? If so please list: _____

_____

_____

_____

_____

Do you have any other condition (medical, physical, emotional, etc) that I should know about before initiating a massage therapy session with you? _____

_____

_____

Please take a moment to carefully read the information you have provided and sign where indicated below. If you have a specific medical condition or specific symptoms, certain massage and bodywork treatments may be contraindicated. A referral from your primary care provider may be required prior to service being rendered.

Client (or guardian):_____ Date: _____