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.

_____
_____
_____

Are you currently seeing a medical professional? Yes____ No _____
If yes, for what reason?

_____
_____

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

_____
_____
_____
_____
_____

Have you ever had surgery? Yes_____ No _____
If yes, please describe all injuries and include dates, diagnosis, and treatment received.

_____
_____
_____

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.)

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* _____