Confidential Health History Information

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Contact Information – *please print for legibility*

Name: _________________________ Today's Date:_________Date of Birth:_______Gender:_____

Address:___________________________City:____________________State:______ Zip:_________

Phone:_____________________ Emergency Contact & Phone: ______________________________

email address:_____________________________ How did you hear of me:_____________________

Goals and Conditions

Main health care goal(s):

Current Medications (pharmaceutical and/or herbal):

Recent surgeries or injuries & approximate dates:

Other health care providers you are currently seeing *(check all that apply):*

___ Medical Doctor ___ Naturopathic Doctor ___ Chiropractor ___ Acupuncturist

__ Physical Therapist ___ Other*(please specify)*

Name(s) & Contact(s) *(if known):*

Health History– *please check all that apply*

___ Tendency toward blood clots

___ Circulatory or heart condition

___ Heavy or unusual menstrual flow

___ Aneurysm

___ Kidney Disorder

___ Recent surgery within past 1 year

___ Joint Stiffness or Pain

___ Lymphatic condition (swollen glands, lymphoma, other)

___ Tendency for dislocations

___ Recent injections (cortisone, Botox)

___ Skin Condition (rash, warts, fungus, athlete's foot, other)

___ Recent injury or deep bruise (esp. knee, hip, shoulder)

___ Neurological condition (sciatica, stroke, epilepsy, other)

___ Bone Conditions (fracture, cancer, osteoporosis, other)

Pain Assessment

What is your average level of Pain?*(1-10)*_____ How often does your Pain bother you?____________

How long have you been experiencing your pain symptoms?__________________________________

Where do you spend most of your time at work (ex. office, factory, lab):________________________

Are you experiencing any of the following? (*Check all that apply)*

___ Headaches ___ Elbow Pain ___ Knee Pain

___ Neck and/or Shoulder Pain ___ Hand/Finger Pain ___ Back Pain

___ Upper Arm ___ Wrist Pain ___ Upper Arm Pain

___ Forearm Pain ___ Hip Pain

___ Other *(please specify)* ____

What best describes your pain symptoms? *(check all that apply)*

___ Cramping Pain ___ Pain only with Movement ___ Numbness

___ Muscle Spasm ___ Sharp, Stabbing Pain ___ Tingling

___ Deep, Aching Pain ___ Stiffness ___ Weakness

___ Other *(please specify)* ____

Office and Financial Policies

- Your time begins when the session begins, but please arrive on time so the day can progress smoothly.
- **Cancellation Policy :** 24 hour notice is requested. We reserve the right to bill you directly for late notice or no-shows (insurance will not cover this fee). Emergency cancellations and no-show or late show charges will be decided at the therapist's discretion.
- I bill qualifying insurance plans. If your sessions with me are not covered, please pay at the time of service.

Statement and Release

- I have chosen to receive massage therapy for the well being of my body, mind and spirit. I agree to communicate with my therapist any time I feel my wellness is being compromised. Massage therapists do not diagnose illness, disease or mental disorders; they also do not prescribe medical treaments, pharmaceuticals, or perform spinal thrust manipulations.
- All information I have provided on this form is true and accurate to the best of my knowledge. I agree to update my therapist on personal, health or other information my therapist may need to conduct treatment safely and effectively.
- I have been given the chance to read the Privacy Policies Notice. I understand that my private health information will be used only for conducting, planning and directing my treatment, consulting with other healthcare providers who may be directly or indirectly in my treatment, or obtaining payment from third-party payers.

___/____/____ ____

Date Signature of patient or guardian if patient is a minor