Personal Health History Information

All information herein is strictly confidential.

Name ____

Birthday ____

Phone (cell) ____

Address ____

City/State/Zip ____

Email ____

Occupation ____

Referred By ____

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?

Health History

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? Yes _____ No _____ Due date: _________________________

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:

Current Symptoms

Please circle yes if these symptoms are occasional or often and note the 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: ____

Types of exercise and 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 and Date

____
Printed Name