health information history & status

Name _____ *Today's Date* _____

Insurance ID _____ *Date of Birth* _____

Policy Number _____ *Work related?* ◯ Yes ◯ No

Injury Form Claim Number _____ *Auto related?* ◯ Yes ◯ No

Phone _____ *Phone* _____ *Email address:* _____

Patient Information

Address _____

City | State | Zip _____

Employer _____

Work Address _____

Occupation _____

Emergency Contact _____

Primary Health Care Provider

Name _____

Address _____

City | State | Zip _____

Phone _____

I give my massage therapist permission to consult with my health care providers regarding my health & treatment.

Initials _____

Date _____

Health History

Please include dates, treatment, and explanation.

Surgeries _____

_____

_____

Injuries _____

_____

_____

Major Illnesses _____

_____

_____

Daily Activities Limited by Condition

_____

_____

_____

_____

Current Health Information

Primary _____

◯ mild ◯ moderate ◯ disabling

◯ constant ◯ intermittant ◯ disabling

◯ discomfort with activity? ◯ getting worse

◯ getting better ◯ no change

Treatment recieved _____

_____

Secondary _____

◯ mild ◯ moderate ◯ disabling

◯ constant ◯ intermittant ◯ disabling

◯ discomfort with activity? ◯ getting worse

◯ getting better ◯ no change

Treatment recieved _____

_____

Additional _____

◯ mild ◯ moderate ◯ disabling

◯ constant ◯ intermittant ◯ disabling

◯ discomfort with activity? ◯ getting worse

◯ getting better ◯ no change

Treatment recieved _____

_____

health information  *health conditions*

Please note all current and previous conditions

General

CURRENT PAST

- ◯ ◯ headaches
- ◯ ◯ pain
- ◯ ◯ sleep disturbances
- ◯ ◯ fatigue
- ◯ ◯ infections
- ◯ ◯ fever
- ◯ ◯ sinus
- ◯ ◯ other

Allergies

CURRENT PAST

- ◯ ◯ scents, oils, lotions
- ◯ ◯ detergents
- ◯ ◯ other

Skin Conditions

PAST PAST

- ◯ ◯ rashes
- ◯ ◯ athlete's foot, warts
- ◯ ◯ other

Habits

CURRENT PAST

- ◯ ◯ tobacco
- ◯ ◯ alcohol
- ◯ ◯ marijuana
- ◯ ◯ coffee & soda
- ◯ ◯ other

Nervous System

CURRENT PAST

- ◯ ◯ head injury, concussion
- ◯ ◯ dizziness, ringing ears
- ◯ ◯ loss of memory, confusion
- ◯ ◯ numbness, tingling
- ◯ ◯ sciatica, shooting pain
- ◯ ◯ chronic pain
- ◯ ◯ depression
- ◯ ◯ other

Muscles & Joints

CURRENT PAST

- ◯ ◯ rheumatoid arthritis
- ◯ ◯ osteoarthritis
- ◯ ◯ scoliosis
- ◯ ◯ broken bones
- ◯ ◯ spinal problems
- ◯ ◯ disk problems
- ◯ ◯ lupus
- ◯ ◯ TMJ & jaw pain
- ◯ ◯ spasms & cramps
- ◯ ◯ tendonitis, bursitis
- ◯ ◯ stiff or painful joints
- ◯ ◯ weak or sore muscles
- ◯ ◯ neck, shoulder, arm pain
- ◯ ◯ low back, hip, leg pain
- ◯ ◯ other

Cancer & Tumors

CURRENT PAST

- ◯ ◯ benign
- ◯ ◯ malignant

Respiratory & Cardiovascular

CURRENT PAST

- ◯ ◯ heart disease
- ◯ ◯ blood clots
- ◯ ◯ stroke
- ◯ ◯ lymphadema
- ◯ ◯ high or low blood pressure
- ◯ ◯ irregular heart beat
- ◯ ◯ poor circulation
- ◯ ◯ swollen ankles
- ◯ ◯ varicose veins
- ◯ ◯ chest pain, breath shortness
- ◯ ◯ asthma

Digestive & Eliminative

CURRENT PAST

- ◯ ◯ bowel
- ◯ ◯ gas, bloating
- ◯ ◯ bladder, kidney
- ◯ ◯ prostrate
- ◯ ◯ abdominal pain
- ◯ ◯ other

Endocrine System

CURRENT PAST

- ◯ ◯ thyroid
- ◯ ◯ diabetes

Reproductive System

CURRENT PAST

- ◯ ◯ painful, emotional menses
- ◯ ◯ fibrotic cysts
- ◯ ◯ pregnancy

health information self-care & contract

Describe Your Self-Care Routines

How do you reduce stress? _____

_____

_____

How do you reduce pain? _____

_____

_____

Please list all current medications & herbal remedies. _____

_____

_____

Have you received massage therapy before? _____

_____

_____

_____

What are your goals for receiving massage therapy? _____

_____

_____

_____

Contract for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self-care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment. Additionally, I agree to give 24 hour notice of appointment cancellation. I also agree to pay a $40 no-show fee if I do not cancel 24 hours in advance.

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature _____ *Date* _____