

Catherine St. Family Chiropractic Massage Therapy Health History Form

Contact Information

Name: _____
 Address: _____ Street _____ City _____ Postal Code _____ Email: _____
 Phone: (h) _____ (w) _____ (c) _____ May I contact you? Yes ___ No ___
 How would you prefer to be contacted? _____
 Emergency Contact Name: _____ Phone: _____

Personal Information

Birth Date: _____ Height: _____ Weight: _____
 Occupation: _____ Have you had a massage before? Yes ___ No ___
 Doctor: _____ Dr's Office Location: _____ Phone: _____

Please indicate all conditions you have experienced. Mark **C** for current or **P** for past.

Joint/Soft Tissue Pain:

- Arms
 - Upper Back
 - Mid Back
 - Lower Back
 - Degenerative Discs
 - Feet
 - Hands
 - Hips
 - Jaw
 - Knees
 - Legs
 - Neck
 - Osteoarthritis
 - Rheumatoid Arthritis
 - Sciatica Limitation of Movement
 - Shoulders
- in which joints: _____

Skin:

- Rashes
- Itching
- Bruise easily
- Dryness
- Boils
- Other _____

Cardiovascular:

- High Blood Pressure
- Low Blood Pressure
- Coronary Heart Disease
- Heart Attack
- Phlebitis
- Stroke / CVA
- Pacemaker
- Heart Murmur
- Palpitations
- Varicose Veins
- Swelling of the Ankles
- Poor Circulation

General Symptoms:

- Fainting
- Dizziness
- Loss of Sleep
- Fatigue
- Nervousness
- Sudden Weight Loss/Gain
- Numbness
- Tingling
- Paralysis
- Headaches (Tension)
- Migraines

Infectious:

- Hepatitis
- Tuberculosis
- HIV
- Herpes
- Cold
- Flu
- Athlete's Foot
- Warts

Digestive:

- Poor Appetite
- Belching/Gas
- Constipation
- Diarrhea
- Nausea
- Ulcer
- Vomiting

Eye, Ear, Nose, Throat:

- Allergies
- Frequent Colds
- Glasses or Contacts
- Hearing Aid
- Hearing Loss
- Sinus Infection
- Swollen Glands

Reproductive: (*Females)

- Pregnant
- Due date _____
- Painful Menstruation
- Heavy Flow
- Irregular Cycle
- Swollen Breasts
- Menopausal
- Pre-menopausal
- Post-menopausal
- Birth control
- Type _____

Respiratory:

- Chronic Cough
- Bronchitis
- Asthma
- Hay Fever
- Difficulty Breathing
- Smoking
- Emphysema
- Pneumonia

Other Conditions:

- Neurological Conditions
- Epilepsy
- Diabetes/Onset: _____
- Allergies _____
- Anaphylaxis: **YES/NO**
- Cancer _____
- Arthritis _____
- "Type" OA/RA/Other: _____
- Where? _____
- Vision Loss
- Hearing Loss
- Constipation
- Insomnia
- Hemophilia
- Kidney/Bladder Problems

ACCIDENT/INJURY

- Car Accident
- Work Related

Date: _____
 Symptoms: _____
 Physical Limitations: _____

CURRENT MEDICATIONS & CONDITIONS

 Pins/Wires/Prosthetics _____

SURGERY

Type: _____
 Date: _____
 Current symptoms: _____

PRESENT INVOLVEMENT IN OTHER HEALTHCARE:

YES / NO
 If Yes, Please Specify: _____

LIFESTYLE

Please circle *Yes* or *No* for the following questions:

- | | | | |
|--------------------------------------|------------|-------------|---|
| 1. Do you eat regularly? | <i>Yes</i> | <i>No</i> | |
| 2. Do you take vitamins? | <i>Yes</i> | <i>No</i> | If yes, what type of vitamins & how often? _____ |
| 3. Do you exercise regularly? | <i>Yes</i> | <i>No</i> | If yes, what form of exercise? _____ |
| 4. Do you use a computer? | <i>Yes</i> | <i>No</i> | If yes, How many hours per day? _____ How many times per week? _____ |
| 5. Do you Smoke? | <i>Yes</i> | <i>No</i> | Amount _____ |
| 6. Do you Sleep Well? | <i>Yes</i> | <i>No</i> | I sleep on my: <u>SIDE</u> <u>STOMACH</u> <u>BACK</u> |
| 7. Consider your Energy Level to be: | | <u>HIGH</u> | <u>UP+DOWN</u> <u>LOW</u> |

FYI: an accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

PLEASE READ CAREFULLY AND SIGN.

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I consent to therapeutic massage treatment by the massage therapist.
- I also understand that I am responsible for any charges incurred in the course of my treatment.
- I understand that 24 hours notice is required to reschedule all future appointments, or charges will apply.
- Please Feel Free to Adjust the Depth/Techniques of the Massage Treatment by Telling the Massage Therapist at any time.
- YOU ARE ALWAYS IN COMPLETE CONTROL OF THE TREATMENT.

Signature

Today's Date