Health History Form

Name: _____ Occupation: _____
Address: _____ City/ State/Zip: _____
W Ph#: _____ H Ph: _____ Birthday: _____ Referred by: _____
E-mail address: _____ EMERGENCY CONTACT: _____

Please fill in the information requested below.

What is your primary reason for seeking massage, polarity or natural healing therapy at this time? What present conditions do you want addressed?

Describe condition. _____

_____

What factors do you believe contribute to this condition? What have you been doing for this condition?

_____

_____

What do you expect from receiving therapy? _____

_____

What previous experience have you had with bodywork? _____

_____

Medical Profile

Are you under a doctor's care? ___Y ___N If Y, explain, and name: _____
_____
Previous surgery/hospitalization? ___Y ___N If Y, explain: _____
_____
Accident or injury within 5 years? ___Y ___N If Y, explain: _____
_____
_____
List current medications: _____
_____

Check all conditions you have had or currently experience:

Past When?	Present Within 1 yr		Past When?	Present Within 1 yr?	
		GENERAL			**SKIN**
___	___	allergies	___	___	abscesses/boils
___	___	depression	___	___	bruises
___	___	edema/swelling	___	___	cancer
___	___	large weight gain/loss	___	___	cuts, open sores
__	___	headaches	___	___	moles, nevus
___	___	fatigue/tiredness	___	___	rashes
___	___	fever	___	___	scars
___	___	flu	___	___	warts
___	___	local infection___			

___ other communicable disease: _____
_____

Past When?	Present Within 1 yr	Past When?	Present Within 1 yr?

CARDIOVASCULAR

___ ___ aneurysm
___ ___ angina
___ ___ heart surgery/CABG
___ ___ heart valve surgery
__ ___ high blood pressure
___ ___ low blood pressure
___ ___ pacemaker
___ ___ phlebitis/blood clots
___ ___ varicose veins
___ ___ other disease/disorder: _____

DIGESTIVE

___ ___ constipation
___ ___ hernia
___ ___ indigestion/heart burn
___ ___ loose bowels
___ ___ nausea
___ ___ severe abdominal pain/s
___ ___ ulcers
___ ___ Other: _____

NEUROMUSCULOSKELETAL

___ ___ arthritis
___ ___ back pain
___ ___ bursitis
___ ___ disc problems
__ ___ fractures
___ ___ joint injuries
___ ___ muscle cramping
___ ___ osteoporosis
___ ___ pinched nerve
___ ___ sciatica
___ ___ tendonitis
___ ___ areas of numbness, weakness, shooting pain:
___ ___ other disease/disorder: _____

SPECIFIC DISORDERS

___ ___ cancer
___ ___ cerebral palsy
___ ___ HIV/AIDS
___ ___ kidney disease
___ ___ multiple sclerosis
___ ___ emotional/mental health problem/s
___ ___ Parkinson's disease
___ ___ seizures
___ ___ stroke
___ ___ Other: _____

Please describe your diet and eating habits:

_____

_____

_____

Do you smoke? _____If yes, how much?_____

Do you drink alcoholic beverages?_____ If yes, how much and how often?_____

Do you exercise? If so, what types and how often? _____

_____

_____

(OPTIONAL)Do you have a spiritual orientation or affiliation? If so, please describe_____

_____

What do you do to manage stress in your life? _____

_____

_____

Additional comments to be considered: