

# PATIENT HEALTH HISTORY

## Massage & Bodywork Healing Arts Studio

To maximize the effectiveness and safety of your massage & bodywork treatment please fill out this confidential questionnaire.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip: \_\_\_\_\_ State: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male/ Female (circle)

Occupation: \_\_\_\_\_ E – Mail: \_\_\_\_\_

What brought you here today? \_\_\_\_\_

Please indicate below any significant medical problems, as such conditions can influence the type and/or depth of work done in any given area.

**Lymphatic condition**

- Lymphoma
- Lymphedema

**Recent injury**

- Whiplash
- Sprain
- Deep bruise

**Circulatory condition**

- Varicose veins
- Phlebitis

Stress

**Neurological condition**

- Sciatica
- Numbness
- Tingling
- Stroke
- Epilepsy

**Joint problems, pain**

- Osteoarthritis
- Rheumatoid
- Gout
- Hypermobility

**Bone conditions**

- Osteoporosis
- Cancer

**Headaches**

- Migraines
- PMS
- Tension
- Cluster

**Emotional difficulties**

- Depression
- Anxiety

Are you pregnant? \_\_\_\_\_

Previous surgery, please state: \_\_\_\_\_

Other medical conditions, please state: \_\_\_\_\_

List medications current taking: \_\_\_\_\_

**\*\*Turn Over Please\*\***

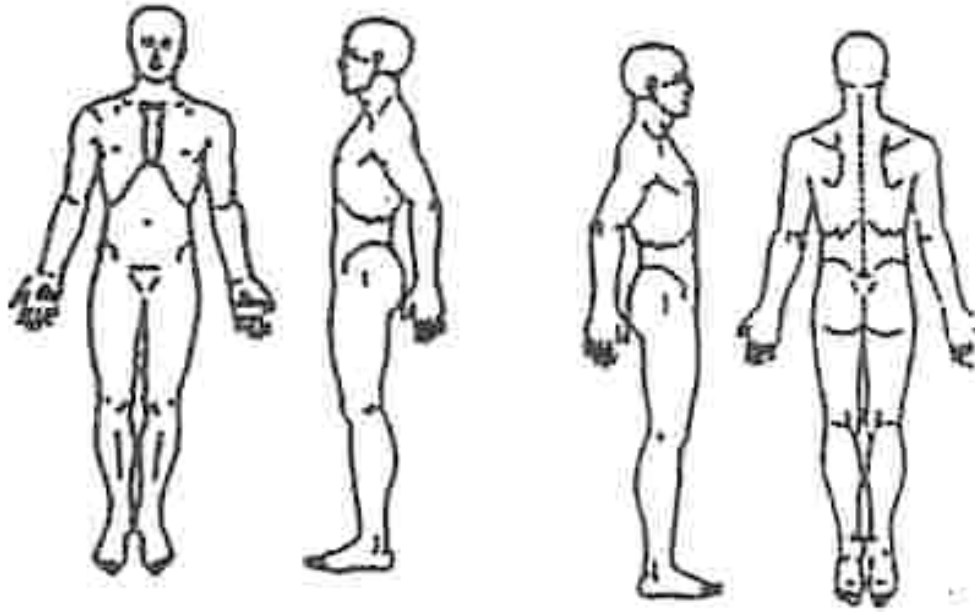
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**Chief Complaint** -- *What are your areas of complaint?*

i.e. Tightness, Pain, Tingling, Numbness, Restricted movement (Place "X" on areas of complaint)

**Pain Scale:** *No Pain* 1 2 3 4 5 6 7 8 9 10 *Extreme*



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