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
__ Hypermobile

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

Revised 01/09

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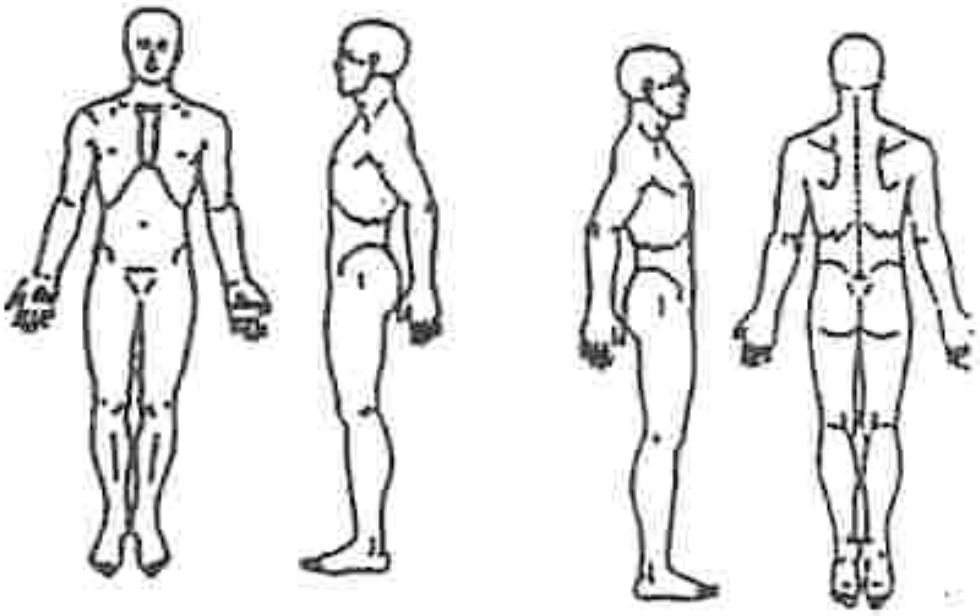
Chief Complaint -- *What are your areas of complaint?*
i.e. Tightness, Pain, Tingling, Numbness, Restricted movement (Place "X" on areas of complaint)

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



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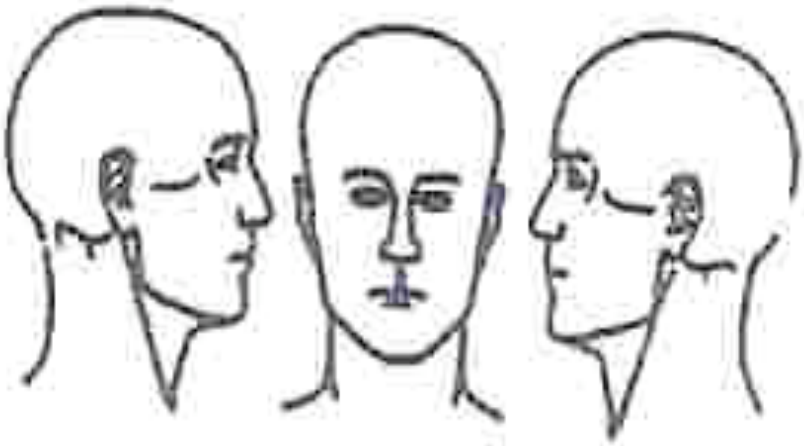

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