Health History Form

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Full Name

_____

Date of Birth

_____

Occupation

_____

Health Insurance Company

_____

Policy Number

_____

Identification/Plan Member Number

_____

Please indicate any health concerns that you are experiencing or have experienced in the past.

Head & Neck Concerns

Headaches Yes ❑ No ❑ Type: _____

Earaches Earaches ❑ Sinusitis ❑ TMJ ❑

Frequency: _____

Other Head and Neck Concerns

_____

Respiratory Concerns

Chronic Cough ❑ Shortness of Breath ❑ Asthma ❑ Smoker ❑ Per day _____

Other _____

_____

Digestive and/or Urogenital Concerns

Crohn's ❑ IBS ❑ Constipation ❑ Liver Disorder ❑ Gallbladder Disorder ❑

Kidney Disorder ❑ Bladder Disorder ❑ Bowel Concerns ❑ Menstrual Problems ❑

Other _____

Cardiovascular Concerns

High Blood Pressure ❑ Low Blood Pressure ❑ Poor Circulation ❑

Heart Disease ❑ What type? _____

Pacemaker ❑ Other _____

Circulatory Concerns

Hemophilia Phlebitis ❑ Atherosclerosis ❑ Raynard's ❑

Varicose Veins ❑ Location_____

Other _____

Muscle & Joint Concerns

Osteoarthritis ❑ Area: _____

Rheumatoid Arthritis ❑ Spinal Disc Injury ❑ Level Affected: _____

Scoliosis ❑ Osteoporosis ❑

Back Pain ❑ Location/Type: _____

Other _____

_____

Skin Concerns

Eczema ❑ Psoriasis ❑ Bruise Easily ❑

Areas Affected: _____

_____

Systemic Concerns

Diabetes ❑ Type: _____

When were you diagnosed? _____

Is it controlled? _____

Hypoglycemia ❑ Epilepsy ❑ Last episode? _____

Cancer ❑ When/Type/Area? _____

Fibromyalgia ❑ HIV ❑ AIDS ❑

Hepatitis ❑ Type: _____

Insomnia ❑ Frequency: _____

Prosthetics/Pins/Plates ❑ Location: _____

_____

Are you being treated for the following:

Anxiety ❑ Depression ❑ Claustrophobia ❑

Allergies ❑ Allergic to what? _____

Sensitivities ❑ Sensitive to what? _____

Reproductive Health

Are you pregnant? Yes ❑ No ❑

Number of births:

_____

Number of pregnancies?

_____

Number of living children?

Place of birth? (ie: hospital, home, birth center)

Did you breastfeed? Yes ❑ No ❑

For how long? _____

Who was your primary caregiver? OB ❑ Family Doctor ❑ Midwife ❑

Did you have a Doula? Yes ❑ No ❑

How was the experience? _____

Type of Delivery Vaginal ❑ Cesarean ❑ VBAC ❑

Complications or Interventions

Did you have postpartum depression? Yes ❑ No ❑

How long and was it treated? _____

Lifestyle Physically Active ❑ Sedentary ❑

Stresses in Life

Have you been in any motor vehicle accidents? Yes ❑ No ❑

Dates: _____

Injuries Sustained: _____

_____

Treatment for injuries: _____

_____

Have you had any major surgeries? Yes ❑ No ❑

Reason(s) and Date(s): _____

_____

When was your last massage?

_____

PLEASE LIST ANY OTHER HEALTH ISSUES THAT ARE NOT LISTED ABOVE:

_____

_____

_____

A complete and accurate health history is very important to ensure that Kelly has a complete picture of you health and to make sure that Massage Therapy is safe for you to receive. If you are a Doula client, it is just as important to have the same picture of your health status so please fill out all areas that apply.

Your massage treatment will begin on the assumption that you have provided an accurate and up to date health history. Kelly will go over this form before your treatment begins. All information that you provide is kept confidential and can only be shared with your written consent.

By signing this document you are agreeing to the cancellation policy: For appointments that are canceled with less than 24 hour notice, you will be charged for the full price of the scheduled service. *This cost to you is not covered by extended health plans.*

I certify that the above information, to the best of my knowledge, is correct.

Print Name: _____ Signature: _____

_____

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