

IMAGINE

MASSAGE THERAPY

CONFIDENTIAL INFORMATION HEALTH HISTORY FORM

Welcome. We want your appointment to be as pleasant and comfortable as possible. If at any time you have questions regarding your visit, please let us know.

PATIENT INFORMATION

Would you like to be added to our mailing list?

Yes No

Name: _____

Home #: _____

Work #: _____

Address: _____

City: _____ ST: _____ ZIP: _____

DOB: ____ / ____ / ____ Age: _____ Sex: _____

Height: _____ Weight: _____

Occupation: _____

Describe any injuries, illnesses, and/or surgical operations (include dates) _____

List any current medications: _____

Who is your regular health care provider/MD? _____

Physician Telephone Number: _____

Have you consumed alcohol, Drugs, or Medications in the past 24 hours?

Yes No Explain: _____

How many times have you received massage therapy? _____

What types? _____

Please indicate the amount of your consumption:

	None	Light	Moderate	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH HISTORY

Please check conditions or symptoms you currently have or have had in the past:

- Contact Lenses
- Allergies / Sinus
- Numbness / Tingling
- Sciatica
- Infectious condition
- Skin condition
- High Blood Pressure
- Inflammation
- Osteoporosis
- Seizures / convulsion
- Dizziness / fainting
- Varicose veins
- Bruise easily
- Arthritis
- Fibromyalgia
- Heart condition
- Difficulty breathing
- Stroke
- Diabetes
- Cancer
- HIV

Neck:

- Whiplash
- Head feels heavy
- Pain w/ movement
- Stiff neck
- Grinding / popping

Head:

- TMJ
- Grind teeth
- Splint
- Headaches
- Migraines
- Vertigo
- Ringing in ears
- Memory Loss
- Light sensitivity

Shoulders:

- Bursitis
- Loss of movement
- Pain with movement

Arms & Hands:

- Hands cold
- Loss of grip
- Pain in wrist

Back:

- Pain when lifting / bending
- Pain with cough / sneeze
- Disk problems
- Sharp Back Pain
- Other: _____

Abdomen:

- Nausea
- Incontinence
- Gas
- Constipation
- Diarrhea
- Tenderness
- Colitis
- Diverticulitis

Hips legs & feet:

- Leg or foot cramps
- Cold feet
- Ticklish feet
- Knee Surgery
- Hip replacement

Males:

- Prostate
- Hernia

Females:

- Pregnant / due date _____
- Irregular cycle
- Endometriosis
- Other _____

Do you have these today?

- Sunburn
- Inflammation
- Severe pain
- Headache
- Open cuts / bruises
- Irritated skin rash / poison ivy
- Cold / flu
- Infections

Name: _____

Date: ____ / ____ / 20____