

Health History Form



Name _____ Date ___/___/___ Occupation _____

Address _____ City _____ State _____

Zip _____ Home Phone _____ Business Phone _____ Who

referred you to this office? _____ Date of Birth ___/___/___

List medications currently taking _____

List any surgeries _____

Please check the following conditions that apply to you, past and present:

- | | | |
|----------------------------------------|----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> bruise easily |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> chest pain | <input type="checkbox"/> numbness |
| <input type="checkbox"/> asthma | <input type="checkbox"/> blood clots | <input type="checkbox"/> limited movement |
| <input type="checkbox"/> fractures | <input type="checkbox"/> heart conditions | <input type="checkbox"/> swollen joints |
| <input type="checkbox"/> cancer | <input type="checkbox"/> edema | <input type="checkbox"/> pinched joints |
| <input type="checkbox"/> disc problems | <input type="checkbox"/> skin disorders | |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> epilepsy | other _____ |
| <input type="checkbox"/> osteoporosis | <input type="checkbox"/> phlebitis | _____ |

Reason for your visit _____

When did the symptoms begin? _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does it interfere with your work, sleep, daily routine, recreation? _____

Date of your last physical exam? ___/___/___ . Top 2 areas that you would like extra time and attention (ex. back, feet etc.) _____

I understand the above information is strictly confidential and is used to help the massage therapist determine any indications or contraindications for massage. I understand that massage therapy is not a replacement for medical care and that no diagnosis will be made. I have informed the massage therapist of all my known physical conditions, medical conditions and medications and I release the Massage Therapist of "be fit massage" from any liability that may occur as a result of this session.

Signature _____ Date ___/___/___

All information shared in a session is held in strict confidence. My goal for this session is that you leave the office with a feeling of wellness and ease of movement – opening all possibilities to a healthier lifestyle.

Thank you for choosing "be fit massage" as part of your wellness plan.