bodywork+ HEALTH HISTORY www.bodyworkplus.net

Please answer all questions completely to ensure safe application of treatments.

Date _____

Name _____ Date of Birth _____

Address _____

Phone _____ Email _____

Emergency Contact _____ Phone _____

Occupation _____Hobbies/Physical Activity _____

What are your goal(s) for treatment? _____

Do you currently have, or do you have a history of any of the following conditions?

Musculoskeletal
☐ Fracture ☐ Osteoporosis (penia) ☐ Arthritis ☐ Other joint disorder ☐ Scoliosis ☐ Joint replacement ☐ Implanted hardware ☐ Hernia
Circulatory
☐ Chest pain ☐ Heart murmur ☐ Heart attack ☐ Stroke ☐Anemia ☐ High blood pressure ☐ Low blood pressure ☐ Varicose veins ☐ Easily bruised ☐ Swelling of the limbs ☐ Clotting disorders
Respiratory
☐ Asthma ☐ Shortness of breath ☐ Wheezing ☐ Cough ☐ COPD
Neurologic
☐ Dizziness ☐ Slurred speech ☐ Weakness ☐ Memory loss ☐ Seizure ☐ Numbness ☐ Loss of consciousness ☐ Loss of balance ☐ Tremor ☐ Sleep disturbances ☐ Concussion
Endocrine
☐ Diabetes ☐ Excessive hunger/thirst ☐ Weight loss ☐ Weight gain
Skin
☐ Skin lesions ☐ Varicose veins ☐ Hives/rash ☐ Itching ☐ Tingling ☐ Changes in color/texture/temperature ☐ Allergy
Digestive
☐ Indigestion ☐ Ulcer ☐ Heartburn ☐ Chron's/IBS ☐ Gas ☐ Weight gain/weight loss ☐ Hernia ☐ Allergy
Female
☐ Irregular menstruation ☐ PCOS ☐ Hysterectomy ☐ Pregnancy ☐ Children, method of childbirth _____ ☐Episiotomy
Male
☐ Prostate issues ☐ Vasectomy ☐ Hernia ☐ Testicular torsion
Other
☐ Cancer ☐ Lymph node removal ☐ Incontinence ☐ Surgery ☐ Trauma ☐ Scars ☐ Motor vehicle accident ☐ Something else? (please explain) _____ _____

Continued on reverse →

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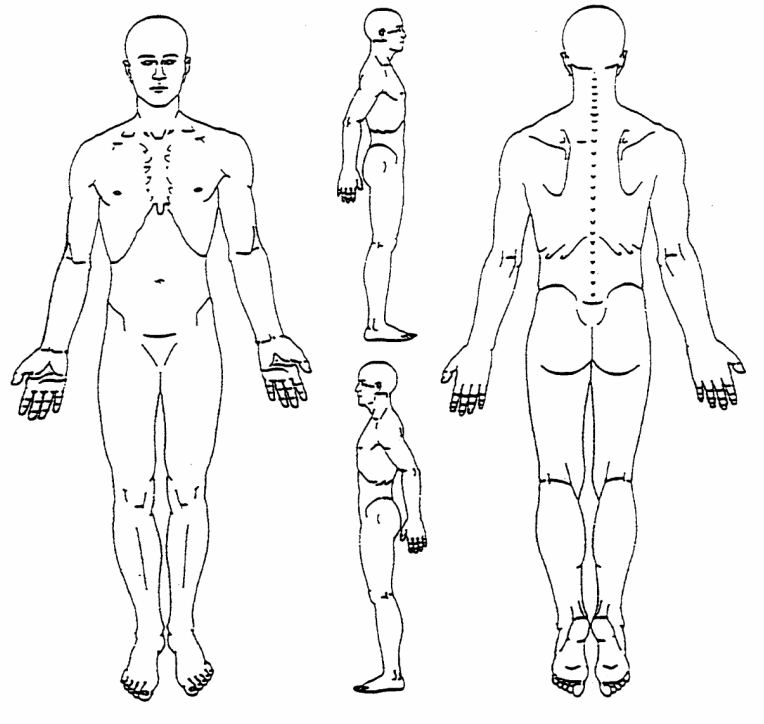
Are you currently taking any meds/supplements/vitamins? **YES / NO If yes,** please list (include dosage):

_____

Please indicate areas of symptomatic sensation on the figures below:



SYMBOL/COLOR KEY
Please use all that apply

Pain = O

Tension = ×

Numbness/Tingling = ≈≈≈

Pinch = *

Stress = ★

Scars = – – –

What is your current level of stress? |_____|_____|
0 (none) 5 (moderate) 10 (severe)

What is your current level of pain? |_____|_____|
0 (none) 5 (moderate) 10 (severe)

Are you currently undergoing treatment for any injury/illness? **YES / NO**

If yes, please describe: _____

TERMS OF AGREEMENT/CONSENT FOR TREATMENT

I certify that the above information is accurate and agree to inform my massage therapist of any changes to my health status. I agree to be an active participant in manual therapy sessions and will discuss any concerns and ask any questions I have as they arise. I understand that agreeing to these terms does not guarantee resolution of pain or pathologies. I understand that many conditions are multi-faceted and manual and/or movement therapy only addresses one realm of the human health condition. I understand that my massage therapist may need to communicate with other health care providers to determine a safe and effective method of treatment (all communication with such providers will be approved prior to discussion).

_____

Signature Date