Client History Form

Name:

Address:

General Information:

Age:

Occupation:

Describe your exercise habits:

Describe your general diet:

Describe how well you sleep, and sleep patterns (i.e. side-sleeper, stomach-sleeper, back-sleeper):

Describe your general health:

Health History:

Have you ever had any surgery or hospitalization?

More than 10 years ago:

5 to 10 years ago:

Less than 5 years ago:

Have you ever been involved in an injury or an accident?

More than 10 years ago:

5 to 10 years ago:

Less than 5 years ago:

What kind of care did you receive?

Do you consider that you have recovered from these events?

Do you have any chronic, ongoing conditions that you deal with on a regular basis? Explain.

Are you taking any medication? Explain.

Are you currently seeing a doctor for any reason? Explain.

Do you have any skin rashes or other skin problems right now?

Are you pregnant?

Treatment goals:

Why are you here? What do you hope to accomplish?

Do you have any questions about massage?

Mark any of the following conditions that you have ever experienced:

Skin

- Boils
- Fungal infections
- Herpes simplex
- Warts
- Eczema
- Psoriasis
- Skin cancer

Musculoskeletal

- Fibromyalgia
- Rheumatoid arthritis
- Osteoarthritis
- TMJ disorders
- Strains, sprains, tendinosis
- Carpal tunnel syndrome
- Thoracic outlet syndrome

Nervous

- Depression
- Eating disorders
- Anxiety disorders
- Multiple sclerosis
- Postpolio syndrome
- Headaches
- Stroke
- Seizure disorders
- Reduced sensation
- Sleep disorders
- Chemical dependency

Circulatory

- Anemia
- Thrombophlebitis
- Deep vein thrombosis
- High blood pressure
- Heart disease
- Varicose veins
- Clotting disorders

Lymph/Immune

- Edema
- Leukemia/lymphoma/myeloma
- HIV/AIDS
- Chronic fatigue syndrome
- Lupus
- Other autoimmune disorders

Respiratory

- Asthma
- Emphysema
- Sinusitis
- Tuberculosis

Digestive

- GERD (reflux)
- Peptic ulcers
- Crohn disease
- Ulcerative colitis
- Irritable bowel syndrome
- Gallstones
- Cirrhosis
- Hepatitis

Endocrine

- Diabetes
- Hyperthyroidism
- Hypothyroidism

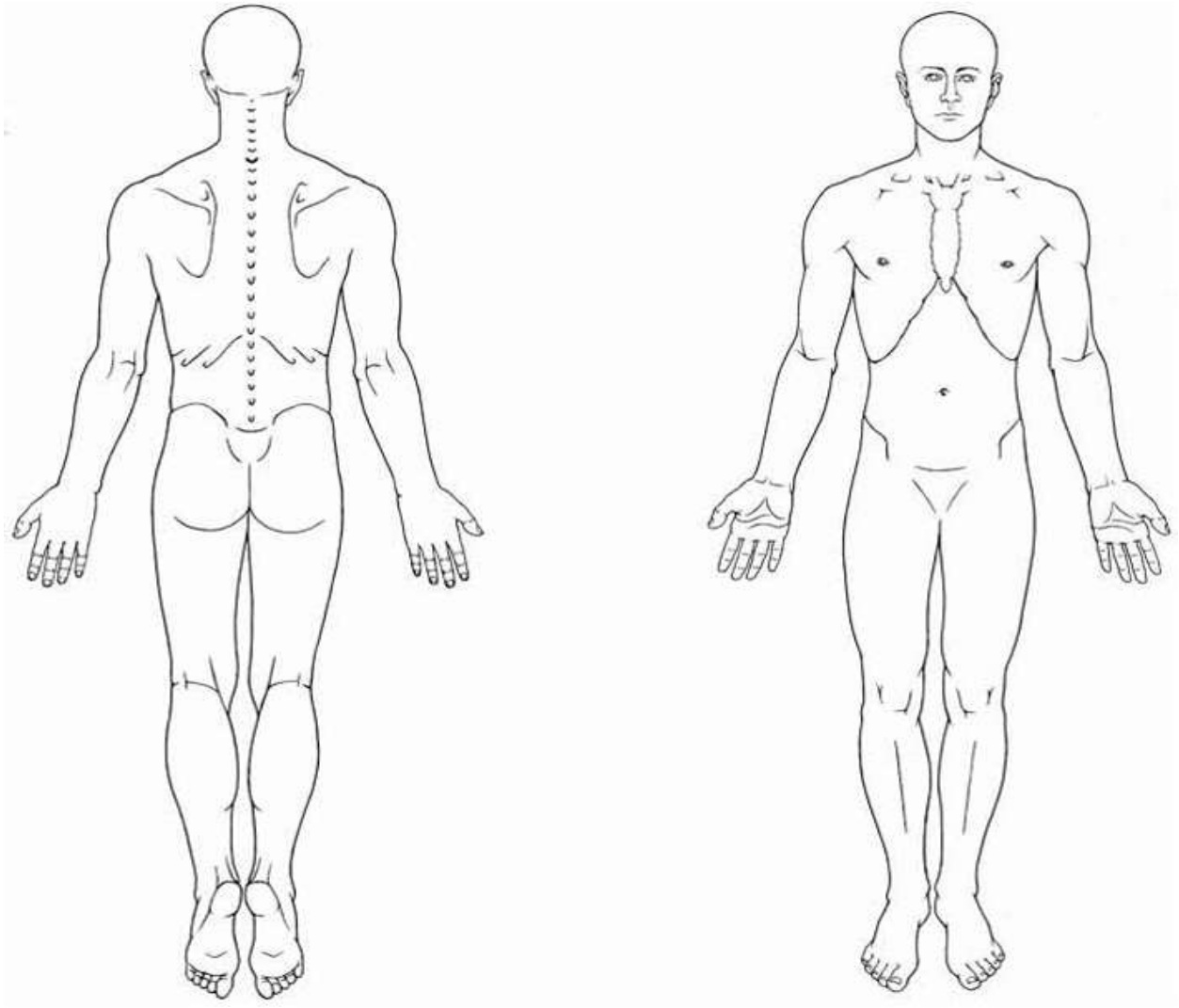
Urinary

- Kidney stones
- Renal failure
- Interstitial cystitis

Reproductive

- Breast cancer
- Endometriosis
- Ovarian cysts
- Benign prostatic hypertrophy (BPH)
- Prostate cancer
- Painful menstruation

Please indicate where you have pain:



Can you describe the character of the pain? (i.e. sharp, stabbing, numbness, tingling, achiness, dullness, etc)

Describe what you do that causes pain, and what activities tend to make it worse:

What activities (if any) give you relief from the pain?