Health History

Check the following conditions that apply to you, past and present. **Please *add your comments* to clarify the condition.**

MusculoSkeletal
- ❑ Headaches
- ❑ Joint stiffness/swelling
- ❑ Spasms/cramps
- ❑ Broken/fractured bones
- ❑ Strains/sprains
- ❑ Hip pain
- ❑ Shoulder, neck, arm, hand pain
- ❑ Leg, foot pain
- ❑ Chest, ribs, abdominal pain
- ❑ Back pain: upper, mid, lower
- ❑ Jaw pain/TMJ
- ❑ Tendonitis
- ❑ Bursitis
- ❑ Arthritis: OA or RA
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Bone or joint disease
- ❑ Other:

Circulatory and Respiratory
- ❑ Dizziness
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Cold feet or hands
- ❑ Cold sweats
- ❑ Swollen ankles
- ❑ Pressure sores
- ❑ Varicose veins
- ❑ Blood clots
- ❑ Stroke
- ❑ Heart condition
- ❑ Allergies
- ❑ Sinus problems
- ❑ Asthma
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Lymphedema
- ❑ Other:

Nervous System
- ❑ Numbness/tingling
- ❑ Twitching of face
- ❑ Chronic pain
- ❑ Sleep disorders
- ❑ Ulcers
- ❑ Paralysis
- ❑ Herpes/shingles
- ❑ Cerebral Palsy
- ❑ Epilepsy
- ❑ Chronic Fatigue Syndrome
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Parkinson's disease
- ❑ Spinal cord injury
- ❑ Other:

Digestive
- ❑ Indigestion
- ❑ Constipation
- ❑ Intestinal gas/bloating
- ❑ Diarrhea
- ❑ Diverticulitis
- ❑ Irritable bowel syndrome
- ❑ Crohn's Disease
- ❑ Colitis
- ❑Other:

Skin
- ❑ Rashes
- ❑ Allergies
- ❑ Athlete's Foot
- ❑ Warts
- ❑ Moles of concern
- ❑ Acne
- ❑ Cosmetic surgery
- ❑ Other:

Recent:
- ❑ Injections
- ❑ Vaccinations
- ❑ Topical Medicines
- ❑ Patches
- ❑ Pumps (with location)
- ❑ Bruising
- ❑ Medication Side Effects

Reproductive System
- ❑ Pregnancy:
  - ❑ Current ❑ Previous
- ❑ PMS
- ❑ Menopause: Pre, Current or Post?
- ❑ Pelvic Inflammatory Disease
- ❑ Endometriosis
- ❑ Hysterectomy
- ❑ Fertility concerns
- ❑ Prostate problems

Other
- ❑ Loss of appetite
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Difficulty concentrating

- ❑ Drug use _____
- ❑Alcohol use _____
  Today?? _____
- ❑ Nicotine use _____
- ❑ Caffeine use _____

- ❑ Hearing impaired
- ❑ Visually impaired
- ❑ Burning upon urination
- ❑ Bladder infection
- ❑ Eating disorder
- ❑ Diabetes: Type I or Type II
- ❑ Fibromyalgia
- ❑ Post/Polio Syndrome
- ❑ Cancer
- ❑ **Infectious disease** (please list)
  _____
- ❑ Other congenital or acquired disabilities (please list)

❑**SURGERIES: (list with year)**

Please list any additional comments regarding your health and wellbeing:

I have stated all conditions that I am aware of and this information is true and accurate. I will keep this Massage Therapist updated as to any changes in my status.

CLIENT'S SIGNATURE: _____ Date:_____