KAREN McLEOD
MASSAGE THERAPY

Health History Form

Home Clinic
29 Shepherd Ave, West Melton
Phone: 03 3436224
Mobile: 027 2004161
Website: www.kmmt.co.nz

NAME: _____

Previous Massages Yes/No _____ How often: _____

Type and frequency of exercise _____

What is your current problem or symptom? _____

Is this getting progressively worse? Yes/No _____ Constant _____ Comes and goes _____

Pain Scale 1 2 3 4 5 6 7 8 9 10

	General Health
	Lymphoedema
	Arthritis
	Diabetes
	Allergies
	Psoriasis/Eczema/ Sensitive skin
	Fungal Infections
	Bursitis
	Infection/Influenza/Cold
	HIV/Hepatitis
	Sinusitis
	Seizures/Convulsions
	High/Low Blood Pressure
	Poor Circulation in hands
	Poor Circulation in feet
	Bruise easily
	Are you pregnant? # wks

	Shoulders and Arms
L/R	Pain (front/back)
L/R	Stiffness (front/back)
L/R	Dislocations (when)
L/R	Carpal tunnel syndrome
L/R	Weakness of grip
L/R	History of injury
L/R	OOS/RSI
L/R	Limited movement
L/R	Numbness/Pins & Needles

	Head & Neck
	Pain in forehead
	Pain in back of head
	Pain in entire head
	Dizziness/Fainting
	Jaw clenching/Teeth grinding
	History of head or neck injury
	Stiff or painful neck movement
	Neck grinding on moving

	Spinal Problems
	Upper/Mid/Lower back
	Disc problem
	Pain/Stiffness (where)
	Worse when sitting/lying
	Worse when bending
	Worse when lifting
	X-ray of bones?

	Hips and Legs/Feet
L/R	Sciatica
L/R	Hip/Knee pain or stiffness
L/R	Hip/Knee replacement
L/R	Leg cramps
L/R	Varicose Veins
L/R	Thrombosis/Clots History
L/R	Numbness/Pins & Needles
L/R	History of injury
L/R	Shin Splints/Gout

	Chest & Abdomen
	Heart problems/Angina
	Shortness of breath
	Asthma
	Respiratory problems
	Abdominal pain
	Constipation/ Diarrhoea
	PMT/Heavy/Painful menstruation

Medication/Supplements - please list

Please circle areas of pain/discomfort