

Health History Form

NAME: _____

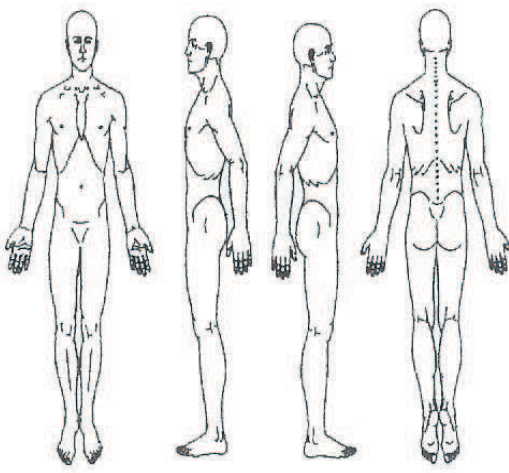
Previous Massages Yes/No _____ How often: _____

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		Head & Neck		Chest & Abdomen	
	Lymphoedema		Pain in forehead		Heart problems/Angina
	Arthritis		Pain in back of head		Shortness of breath
	Diabetes		Pain in entire head		Asthma
	Allergies		Dizziness/Fainting		Respiratory problems
	Psoriasis/Eczema/ Sensitive skin		Jaw clenching/Teeth grinding		Abdominal pain
	Fungal Infections		History of head or neck injury		Constipation/ Diarrhoea
	Bursitis		Stiff or painful neck movement		PMT/Heavy/Painful menstruation
	Infection/Influenza/Cold		Neck grinding on moving	Medication/Supplements - please list	
	HIV/Hepatitis	Spinal Problems			
	Sinusitis		Upper/Mid/Lower back		
	Seizures/Convulsions		Disc problem		
	High/Low Blood Pressure		Pain/Stiffness (where)		
	Poor Circulation in hands		Worse when sitting/lying		
	Poor Circulation in feet		Worse when bending		
	Bruise easily		Worse when lifting		
	Are you pregnant? # wks		X-ray of bones?		
Shoulders and Arms		Hips and Legs/Feet		Please circle areas of pain/discomfort 	
L/R	Pain (front/back)	L/R	Sciatica		
L/R	Stiffness (front/back)	L/R	Hip/Knee pain or stiffness		
L/R	Dislocations (when)	L/R	Hip/Knee replacement		
L/R	Carpal tunnel syndrome	L/R	Leg cramps		
L/R	Weakness of grip	L/R	Varicose Veins		
L/R	History of injury	L/R	Thrombosis/Clots History		
L/R	OOS/RSI	L/R	Numbness/Pins & Needles		
L/R	Limited movement	L/R	History of injury		
L/R	Numbness/Pins & Needles	L/R	Shin Splints/Gout		