**Patient Health History**

**Patient Name: Date of Birth:**

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| --- | --- |
| **Where is your problem?** (please circle)  Shoulder Knee Elbow  Neck Back Other  **Dominant Arm?** Right / Left  **Problem(s)** (please check /circle all that apply):  􀀀 Pain?  􀀀 Weakness / Instability / giving way?  􀀀 Dizziness / Headache / Numbness?  􀀀 Stiffness / Fatigue?  􀀀 Swelling. / Deformity?  􀀀 Other  **How long have you had symptoms?**  Days Months Yrs.  **Current Medications (for):** | **How did you injure yourself?**  􀀀 No injury – just started hurting  􀀀 Sports (which sport?)  􀀀 Motor vehicle accident  􀀀 Work / job –  Is there a worker’s comp claim? Yes / No  **Please briefly describe the injury:**  **If involved in a motor vehicle accident:**  You were: Driver Passenger Pedestrian  You were struck from Back Front Left Side Right side  You were taken to a hospital? No / Yes  You were lost consciousness? No / Yes |

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| **1Where is your pain?**  **2** | **How severe is your pain?**  **1 2 3 4 5 6 7 8 9 10**  No Pain Severe Pain  **Your Current Limitations:**  **Have you had any** X-rays: No / Yes Date:  SCAN/MRI No / Yes Date: |

Please Circle The option that applies:

**Do You live in:** Apartment House Any stairs (If yes How many?)

**You live:** Alone Spouse and/or others

**Do you exercise regularly?** Yes No

**Sports level:** None / Recreational / College / Professional

**Occupation:**

**Health History:** Please indicate conditions you are experiencing or have experienced.

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| **Respiratory**  Other Conditions   * Chronic cough * Shortness of breath * Bronchitis * Asthma * Emphysema * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Cardiovascular**   * High blood pressure * Low blood pressure * CHF * Heart attack * Phlebitis * Stroke/CVA * Pacemaker or similar device * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Family History**   * Arthritis * Cancer * Diabetes * Heart disease/ stroke * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Other Conditions**   * Diabetes: onset \_\_\_\_\_\_\_ * Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_ * Cancer * Arthritis * Migraines &/or headaches * Loss of sensation * Vision problems * Vison loss * Ear problems * Hearing loss * Skin conditions * Hepatitis * TB * HIV * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Cigarette/ Tobacco Consumption**   * Yes- amount \_\_\_\_\_/ day * no | **Women**   * pregnant: due: \_\_\_\_\_\_\_\_   **Soft Tissue/ Joint Discomfort**   * Neck * Low back * Mid back * Upper back * Shoulders * Arms * Hands * Hips   Legs   * Knees * Feet * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Rate your General Health**   * Above average * Average * Below average |

**Have you received massage therapy before? Yes No**

**Patient Signature Date**

**Therapist Signature Date**