**Patient Health History**

**Patient Name: Date of Birth:**

|  |  |
| --- | --- |
| **Where is your problem?** (please circle)Shoulder Knee ElbowNeck 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 PedestrianYou were struck from Back Front Left Side Right sideYou were taken to a hospital? No / YesYou were lost consciousness? No / Yes |

|  |  |
| --- | --- |
| **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.

|  |  |  |
| --- | --- | --- |
| **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**