

Health History Form

FYI: an accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

La Vita Sana Chiropractic

Personal Information

Name: _____ Date: _____ Email: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Occupation: _____ Date of Birth: _____ Height: _____ Weight: _____

Reason for Massage: _____

On a scale of 1 to 10, where 1 is low and 10 is high, what is the usual intensity of your pain? _____

Have you had a massage before? Yes No How long ago was your last massage? _____

Current Medications: _____

Previous Major Illnesses, Operations: _____

Accidents (please give dates): _____

Other Medical Conditions (e.g. hemophilia, diabetes): _____

Family History (major illnesses, operations): _____

Please indicate all conditions you have experienced. Mark C for current and P for past

Joint/Soft Tissue Discomfort

- Arms
 - Upper Back
 - Mid Back
 - Lower Back
 - Degenerative Discs
 - Feet
 - Hands
 - Hips
 - Jaw
 - Knees
 - Legs
 - Neck
 - Osteo Arthritis
 - Rheumatoid Arthritis
 - Sciatica
 - Shoulders
 - Limitation of Movement
- in which joints: _____
- Other: _____

Skin

- Rashes
 - Itching
 - Bruise Easily
 - Dryness
 - Boils
- Other: _____

General Symptoms

- Fainting
- Dizziness
- Loss of Sleep
- Fatigue
- Nervousness
- Sudden Weight Loss/Gain
- Numbness
- Tingling
- Paralysis
- Headaches (Tension)
- Migraines

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Coronary Heart Disease
- Heart Attack
- Phlebitis
- Stroke / CVA
- Pacemaker
- Heart Murmur
- Palpitations
- Varicose Veins
- Swelling of the Ankles
- Poor Circulation

Infectious

- Hepatitis
 - Tuberculosis
 - HIV
 - Herpes
 - Cold
 - Flu
 - Athlete's Foot
 - Warts
- Other: _____

Digestive

- Poor Appetite
- Belching/Gas
- Constipation
- Diarrhea
- Nausea
- Ulcer
- Vomiting

Eye, Ear, Nose, Throat

- Allergies
- Frequent Colds
- Glasses or Contacts
- Hearing Aid
- Hearing Loss
- Sinus Infection
- Swollen Glands

Client Name: _____

Please indicate all conditions you have experienced. Mark C for current or P for past

Reproductive

- Pregnant
due date: _____
- Painful Menstruation
- Menopausal
- Pre-menopausal
- Post-menopausal

Respiratory

- Chronic Cough
- Bronchitis
- Asthma
- Hay Fever
- Difficulty Breathing
- Smoking
- Emphysema
- Pneumonia

Lifestyle Questions

Regular Eating Habits Yes No

Do you take vitamins? Yes No

Type: _____

Frequency: _____

Regular Exercise Yes No

Type: _____

Frequency: _____

Energy Level: High Average Low

Do you suffer from stress? Yes No

Cause: _____

Do you use a computer? Yes No

How many hours per day: _____

Please read carefully, and sign.

I attest that the information I have provided is true and complete to the best of my knowledge.
I understand the information I have provided is confidential and will not be released without my written consent.
I consent to therapeutic massage treatment.
I also understand that I am responsible for any charges incurred in the course of my treatment.
I understand that 24 hours notice is required to reschedule all future appointments, or full charges will apply.

Signature

Today's Date

Please indicate areas of discomfort

