The Body Mechanist

Health History Form

Please complete both sides of this form. This information will help me assess your needs before any hands-on work is done in order to provide you with the highest quality of care. Information provided on this form will be kept confidential.

Name:____ Date:__________________

Address:____

____

E-mail: ________________________________ Check here to receive specials via e-mail ☐

Phone:___________________________ Birthday:__________________________

How did you hear about us?____

Occupation and occupational activity (e.g. heavy lifting):__________________________

Do you exercise? ☐Yes ☐No

How often?________________________ What type?________________________

Other recreational activities?____

On a scale of 1 to 10 what is the amount of stress/tension in your life?_____________

What are your specific areas of tension?____________________________________

Have you had a massage before? ☐Yes ☐No

If yes, how long ago?____

Was there anything in particular that you did or didn't like?_____________________

____

Are you currently under a doctor's care?____________________________________

Are you taking any medications?____

Is there anything else that you feel would be helpful for the massage therapist to know?

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PLEASE FLIP FORM OVER AND FILL OUT BACK

General Symptoms

Please mark whether or not you are experiencing any of the following general symptoms at the present time. Be sure to add any comments that might further clarify (i.e. location on the body, names of conditions, and doctor's specific advice about the condition)

			Comments:
Any swelling or tendency to swell	☐ Yes	☐ No	______________________
Any sites of pain or tenderness	☐ Yes	☐ No	______________________
Any sites of numbness	☐ Yes	☐ No	______________________
Any sites of infection	☐ Yes	☐ No	______________________

Specific Medical Conditions

If you have ever had any of the following conditions, please mark whether it was past or current and add any comments that might further clarify.

				Comments:
Skin Conditions (e.g. rashes, infections, itching)	☐ Past	☐ Current	☐ No	______________________
Known Allergies	☐ Past	☐ Current	☐ No	______________________
Cardiovascular Conditions (e.g. high blood pressure, heart condition, angina, phlebitis, blood condition, hardened arteries, etc.)	☐ Past	☐ Current	☐ No	______________________
Liver or Kidney Conditions	☐ Past	☐ Current	☐ No	______________________
Respiratory/Lung Conditions	☐ Past	☐ Current	☐ No	______________________
Cancers or Tumors (either malignant or benign)	☐ Past	☐ Current	☐ No	______________________
Diabetes	☐ Past	☐ Current	☐ No	______________________
Arthritis	☐ Past	☐ Current	☐ No	______________________
Pregnancy	☐ Past	☐ Current	☐ No	______________________
Injuries (e.g. disc problems, fractures, knee problems, tendonitis)	☐ Past	☐ Current	☐ No	______________________
Headaches (e.g. chronic, severe, etc.)	☐ Past	☐ Current	☐ No	______________________

Other medical conditions not mentioned above ____

Consent for Care

- It is my choice to receive manual therapy, and I give my consent to receive treatment.
- I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.
- I understand that manual therapists can not diagnose illness, disease or any other mental or physical disorder, and I am not seeking manual therapy in lieu of a physician's care.
- I also understand that I am in complete control of treatment, and I can ask the therapist to adjust the depth/technique at any time during my session.

Signature: ________________________________ Date: ______________________