Health History Form

A complete and accurate health history is very important to ensure that Kelly has a complete picture of you health and to make sure that Massage Therapy is safe for you to receive.

If you are a Doula client, it is just as important to have the same picture of your health status so please fill out all areas that apply.

Your massage treatment will begin on the assumption that you have provided an accurate and up to date health history.

Kelly will go over this form before your treatment begins. All information that you provide is kept confidential and can only be shared with your written consent.

Name: ____________________

Date of Birth: ____________________

Occupation: ____________________

Health Insurance Company: ____________________

Policy Number: ____________________

Identification/Plan member Number: ____________________

Please indicate any health concerns that you are experiencing or have experienced in the past. (Circle all of those that apply)

Head and Neck Concerns

Headaches

Type:

Earaches Sinusitis TMJ

Frequency: ____________________

Other: ____________________

Respiratory Concerns:

Chronic Cough

Shortness of Breath

Asthma

Smoker Number/ Day: ____________________

Other: ____________________

Evolution Massage Therapy

Digestive and/or Urogenital Concerns:

Cohn's

IBS

Constipation

Liver disorder

Gallbladder disorder

Kidney disorder

Bladder disorder

Bowel concerns

Menstrual Problems

Other: ______________________________

Cardiovascular Concerns

High Blood pressure

Low Blood pressure

Poor circulation

Heart disease

Type: ______________________________

Pacemaker

Other: ______________________________

Circulatory Concerns

Hemophilia Phlebitis

Atherosclerosis

Raynaud's

Varicose Veins

Location: ______________________________

Other: ______________________________

Evolution Massage Therapy

Muscle and Joint Concerns:

Osteoarthritis

Area: ____________________

Rheumatoid Arthritis

Spinal Disc Injury

(levels affected if you know): ____________________

Spinal Disc Disease

Scoliosis

Osteoporosis

Other: ____________________

Back Pain

Location / Type (acute, intermittent or chronic): ____________________

Skin Concerns

Eczema:

Areas affected: ____________________

Psoriasis

Areas affected: ____________________

Bruise easily

Areas affected: ____________________

Evolution Massage Therapy

Systemic Concerns:

Diabetes

Type: ______________________________

When where you diagnosed?: ______________________________

Is it controlled?: ______________________________

Hypoglycemia

Epilepsy

When was your last episode? ______________________________

Cancer

When / Type / Area: ______________________________

Fibromyalgia

HIV

Aids

Hepatitis

Type: ______________________________

Insomnia:

Chronic or Occasional

Prosthetics/Pins/Plates

Location: ______________________________

Are you being treated for the following?

Anxiety

Depression

Claustrophobia

Allergies

To What: ______________________________

Sensitivities

To What: ______________________________

Evolution Massage Therapy

Reproductive Health:

Are you pregnant? ______________________________

Number of births? ______________________________

Number of pregnancies? ______________________________

Number of living children? ______________________________

Place of birth? (I.e. Hospital, home or birth center) ______________________________

Did you breastfeed and for how long? ______________________________

Who was your primary care provider?

OB   Family Doctor   Midwife

Did you have a Doula? And if so how was the experience?

____

____

____

Type of delivery:

Vaginal   Cesarean   VBAC

Complications or Interventions:

____

____

____

Did you have Postpartum depression?

How long and was it treated? ______________________________

Lifestyle

Physically Active   Sedentary

Stresses In Life:

____

____

____

Motor Vehicle Accidents

Date(s): ______________________________________

____

Injuries sustained: _____________________________

____

____

Treatment for them: ____________________________

____

____

Surgeries: Reasons and Date:

____

____

____

When was your last massage?

____

Please list any other health issues that are not listed:

____

____

____

The above information, to the best of my knowledge, is accurate and up to date.

Signature: ________________________ Date: ________________