Health History Section

Name: Date:

What brought you here today?

If you have physical discomfort, where is it located:

Is your discomfort an ache or a pain?

Do you have difficulty sleeping? _____ If yes, do you have difficulty getting to sleep or staying asleep? _____ If you have difficulty staying asleep, what time do you usually wake up? _____

Have you experienced any recent injuries, surgeries, accidents and/or broken bones? _____
If yes, please describe:

Do you have any circulatory or respiratory problems, high blood pressure, asthma, etc.?
Please describe:

Do you take medications for the above? _____ If yes, what, how much and how often?

_____ _____ _____

Please Document Your History of Illness, Surgeries, Diseases, Disorders, Broken Bones, etc.

What When (approximate date)

Please list any medications taken within the last six months. (Include motrin, aspirin, etc., vitamins, herbs.)

Please sign below. Your signature is your consent to treatment for therapeutic massage. You are also confirming that you have provided accurate and complete health information.

Signature: _____Date: _____