Healthtouch

Confidential Health History

Name: _____ DOB _____ Date: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Occupation: _____ Email: _____

Marital Status: _____ # of Children: ___ Pregnant? ___ Miscarriages/Terminations: _____

Glasses? _____ Contacts? _____ Dentures? _____ Last Massage: _____

How did you hear of us? _____

What do you do for pain management? _____

Currently under a Doctor's care and for what condition? _____

Please list all medications, herbs, homeopathics, vitamins and supplements you are currently taking:

_____

_____

Do you have pain now? ____ If yes, when did it start? _____ How often? _____

On a scale of 1-10 (low to high), indicate the location, description and intensity of the pain: _____

_____

_____

_____

_____

Previous surgeries and dates: _____

Previous and current sprains, strains, breaks, dislocations and fractures and dates:

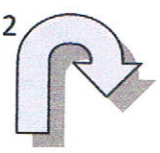
_____

_____

Any other information you feel may be helpful: _____

_____

TURN OVER TO COMPLETE PAGE 2



HealthTouch Bodywork Systems, Inc.

Nutritional Info – Quantity & Frequency
Coffee/Tea
Soda
Chocolate
Sugar
Alcohol
Tobacco
Water

Type of Exercise & Frequency

PLEASE CHECK ALL THAT APPLY
(Past and Present)

_____Neck Pain
_____Neck Stiffness
_____Shoulder Pain
_____Upper Back Pain
_____Mid Back Pain
_____Low Back Pain
_____Muscular cramps
_____Numbness/tingling
_____TMJ
_____Headaches
_____Sciatica
_____Joint Immobility
_____Knee Pain
_____Hip Pain
_____Arthritis
_____Bursitis
_____Scoliosis
_____Implants
_____Other health condition(s) not listed

_____Menstrual Problems
_____Constipation
_____Allergies
_____Skin Problems
_____Open sore/wound
_____Contagious health/skin conditions
_____Stress
_____Depression
_____Nervousness/Anxiety
_____Insomnia
_____MS
_____CP
_____Heart Disease
_____Phlebitis
_____Varicose Veins
_____History of Blood Clots
_____Tumors
_____Fibromyalgia

PLEASE SHADE ALL AREAS OF PAIN, DISCOMFORT AND STIFFNESS: