Health History

Name:_____ Date of Birth:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

Email address:_____
(for internal use only)
Occupation: (past or present)_____

Emergency Contact: Name_____ Relationship_____

Phone_____ Alternate Phone_____

Whom may we thank for your referral? _____

Primary Physician: _____ Phone number:_____
Specialist: _____ Phone number:_____

Are you under the care of any of the following? (Check all that apply):

( ) Medical Doctor (MD)	( ) Psychiatrist/Psychologist	( ) Personal Trainer
( ) Osteopath	( ) Physical Therapist	( ) Nutritionist
( ) Dentist	( ) Chiropractor	( ) Massage Therapist

If you have seen any of the above in the past three months, briefly describe the reason (illness, medical condition, physical, etc.): _____
_____
_____

Please describe the reason you are seeking treatment or any significant medical history (surgeries,, physical or emotional trauma, accidents)
_____
_____
_____

Please list any significant family history_____
_____

List any PRESCRIPTION medications you are taking: (prescription or OTC)
1. _____ 2._____ 3._____ 4._____

What would a successful outcome look like to you?

Short Term _____

_____

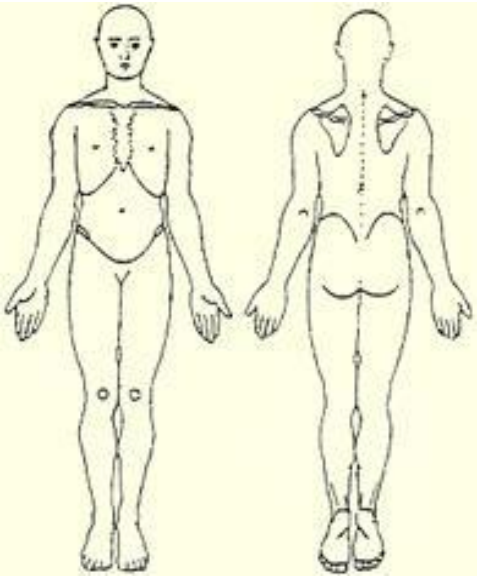
_____

Long Term _____

_____

_____

Please indicate symptoms you are currently experiencing on the diagram below:



Do your symptoms make it difficult for you to sleep well? YES NO
(circle all that apply)

Difficulty falling asleep

Waking up due to pain

Difficulty returning to sleep

Describe any positions that make symptoms worse;

Sitting Standing Squatting Bending Twisting

Reaching overhead

Other _____

Describe any positions that make symptoms better;

Sitting Standing Walking or movement Laying down

Other_____

Women: Are you (or could you be) pregnant? _____

Number of children: _____ Vaginal or Caesarian birth? (circle)

Is there anything that hasn't been listed that your therapist should know?_____

_____

I understand the relationship I have with my myofascial release therapist is a partnership. I have the right to ask questions regarding my treatment as well as refuse any part of treatment that has been recommended. My signature gives my consent to be treated.

_____ _____ _____

Patient Name Signature Date