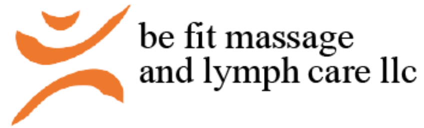

Health History Form

Name__________________________ **Date**___/___/___ **Occupation**________________

Address_________________________ **City**______________ **State** ___ **Zip**_________

Cell Phone __________________ **e-mail** _____________________________________

Who referred you to this office?_____________________ **Date of Birth** ___/___/___

List medications currently taking____
List any surgeries____

Please check the following conditions that apply to you, past and present:

____ arthritis	____ high blood pressure	____ bruise easily
____ neck pain	____ chest pain	____ numbness
____ asthma	____ blood clots	____ limited movement
____ fractures	____ heart conditions	____ swollen joints
____ cancer	____ edema	____ pinched joints
____ disc problems	____ skin disorders	
____ diabetes	____ epilepsy	other______________________
____ osteoporosis	____ phlebitis	__________________________

Reason for your visit ____
When did the symptoms begin? ____
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ________
How often do you have this pain? __________ Is it constant or does it come and go?____
Does it interfere with your work, sleep, daily routine, recreation? ___________________
Date of your last physical exam? ___/___/___. Top 2 areas that you would like extra time and attention (ex. back, feet etc.) ____________________________________

I understand the above information is strictly confidential and is used to help the massage therapist determine any indications or contraindications for massage. I understand that massage therapy is not a replacement for medical care and that no diagnosis will be made. I have informed the massage therapist of all my known physical conditions, medical conditions and medications and I release the Massage Therapist of ***"be fit massage and lymph care llc"*** from any liability that may occur as a result of this session.

Signature________________________ **Date** ___/___/___

All information shared in a session is held in strict confidence. My goal for this session is that you leave the office with a feeling of wellness and ease of movement – opening all possibilities to a healthier lifestyle.
Thank you for choosing *"be fit massage and lymph care llc"* as part of your wellness plan.