

A Heart for Healing Massage Therapy, LLC

503-533-7901

HEALTH INFORMATION

Patient Information

Name: _____

Address: _____

City/State/Zip: _____

DOB: _____ Occupation: _____

Referred by: _____

Phone # Day: _____

Evening: _____

Cell / Pgr: _____

Email address: _____

Emergency Contact: _____

Number: _____

Primary Health Care Provider

Name: _____

Address: _____

City/State/Zip: _____

HCP Ph #: Office: _____

Fax: _____

Permission to consult with relevant health care provider? Yes No Initials: _____ Date: _____

Comments _____

General Questions

Have you ever received a professional massage? Yes No Type/Frequency _____

Are you currently being seen by a Health Care Provider? Yes No MD, Chiropractor, Physical Therapist, etc.

Please explain _____

List current medications (include pain relievers and herbal remedies): _____

List stress reduction and exercise activities and frequency: _____

Previous History

List and explain. Include dates and treatments received.

Surgeries: _____

Accidents: _____

Major Illnesses: _____

General

Current	Past	Comments
	headaches	_____
	pain	_____
	sleep	_____
	fatigue	_____
	infections	_____
	fever	_____
	sinus	_____
	other	_____

Skin Conditions

Current	Past	Comments
	rashes	_____
	athlete's foot	_____
	warts	_____
	other	_____

Allergies

Current	Past	Comments
	scents, oils, lotions	_____
	_____	_____
	detergents	_____
	other	_____

Muscles and Joints

Current	Past	Comments
	rheumatoid arthritis	_____
	_____	_____
	osteoprosis	_____
	scoliosis	_____
	broken bones	_____
	spinal problems	_____
	disk problems	_____
	lupus	_____
	TMJ, jaw pain	_____
	spasms, cramps	_____
	_____	_____
	sprains, strains	_____
	tendonitis, bursitis	_____
	_____	_____
	stiff or painful joints	_____
	_____	_____
	weak or sore muscles	_____
	neck, shoulder, arm pain	_____
	_____	_____
	low back, hip, leg pain	_____
	_____	_____
	other	_____

General

Current	Past	Comments
	head injuries, concussions	_____
	_____	_____
	dizziness	_____
	ringing in the ears	_____
	_____	_____
	loss of memory, confusion	_____
	_____	_____
	numbness, tingling	_____
	_____	_____
	sciatica, shooting pain	_____
	_____	_____
	chronic pain	_____
	depression	_____
	other	_____

Respiratory, Cardiovascular

Current	Past	Comments
	heart disease	_____
	blood clots	_____
	stroke	_____
	lymphadema	_____
	_____	_____
	high, low blood pressure	_____
	_____	_____
	irregular heart beat	_____
	_____	_____
	poor circulation	_____
	swollen ankles	_____
	varicose veins	_____
	chest pain, shortness of breath	_____
	_____	_____
	asthma	_____
	other	_____

Cancer / Tumors

Current	Past	Comments
	benign	_____
	malignant	_____

Digestive / Elimination System

Current	Past	Comments
	bowel dysfunction	_____
	gas, bloating	_____
	bladder / kidney dysfunction	_____
	_____	_____
	abdominal pain	_____
	other	_____

Endocrine System

Current	Past	Comments
	thyroid dysfunction	_____
	_____	_____
	diabetes	_____
	other	_____

Reproductive System

Current	Past	Comments
	pregnancy	_____
	painful, emotional menses	_____
	_____	_____
	fibrotic cysts	_____
	other	_____

Habits

Current	Past	Comments
	tobacco	_____
	alcohol	_____
	drugs	_____
	coffee, soda	_____

Other Health Concerns

_____	_____
_____	_____

Contract for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self-care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

Consent for Care

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature _____ Date _____

Signature of parent or guardian _____ Date _____
(If patient is a minor)