CLIENT HEALTH HISTORY NAME: _____ DATE: _____

This questionnaire has been designed to help me provide the best professional care and service. The information contained herein will be kept in strict confidence.

Address: _____

Email: _____
Email reminders are sent from Genbook 24 hours before your scheduled appointment. Occasional emails are sent out for specials and discounts. You can request to be removed from the email list at any time.

Phone: (cell/work) _____ (home) _____
Please circle preferred method of communication above.
It is acceptable to call between the hours of _____a.m. and _____p.m.

Date of Birth: _____ Age: _____ Occupation: _____

Referred by: _____ Can I let the referrer know you came in today so they can get the referral discount? _____Please initial to give permission _____

Please list your primary health care professionals (MD, Chiropractor, Osteopath, NP, etc.)
_____ Phone: _____
_____ Phone: _____

Emergency Contact_____ Phone: _____

Do you wear contacts? _____ Dentures? _____ Are you pregnant? _____ If so, how many months? _____

Are you involved in any other therapy at this time? If so, what, and how often?
_____

Are you currently taking medications? Please list medications, dosages, and what they are treating-
_____
_____

Do you have any current known: Please elaborate if checked.
_____ injuries _____
_____ bruises _____
_____ infections _____
_____ contagious diseases _____
_____ allergies or sensitivities (food, inhalants or smells, detergents, latex, oils, balms, liniments, etc.)
_____

Do you have any of the following?

_____ high blood pressure
_____ low blood pressure
_____ any know blood clots
_____ arthritis or bursitis
_____ heart problems
_____ kidney problems
_____ emotional sensitivities
_____ degenerative discs

Please list any previous injuries (broken bones, severe sprains, whiplash, traumas, etc.) and surgeries-
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
Continue on a separate sheet, if needed.

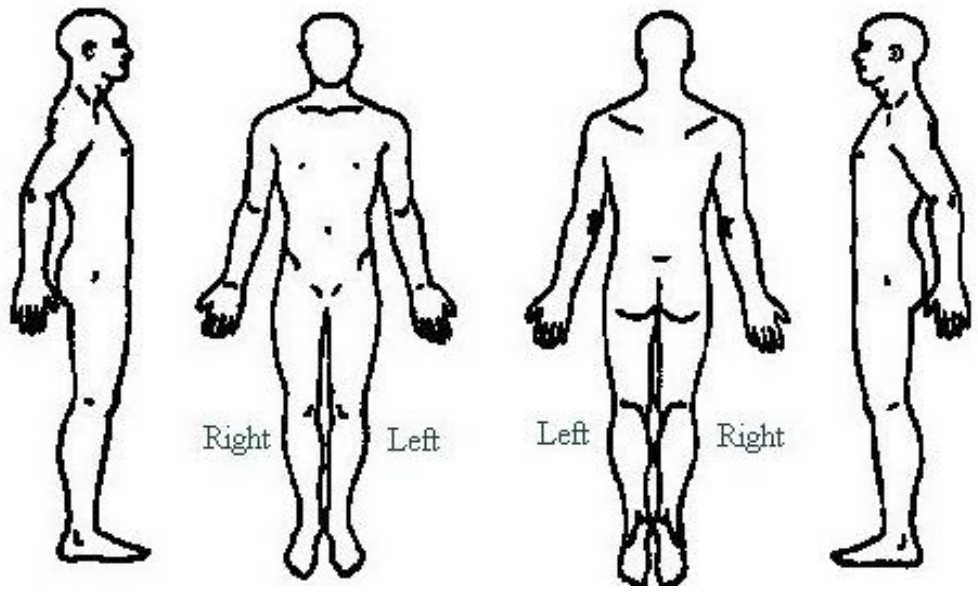
Which hand do you write with? L or R

Do you feel as if you "hold" stress or tension in any part of your body? (please circle) YES NO
If "yes," is it occasional _____ or frequent _____ ?

Do you experience any of the following?

_____ chronic headaches
_____ chronic backaches
_____ bruxism (clenching, grinding of the teeth)
_____ tightness in the jaw (especially upon waking)

On the diagram below, please circle those areas that best correspond to the places where you feel you hold stress, tension, or those areas where you may be currently experiencing discomfort or pain:



Right Front Back Left

What type(s) of exercise or activities do you do? How often? _____
_____

How would you describe your dietary habits? _____
Approximately how many ounces of water do you drink per day *(not including soda, coffee, or tea)*? _____

What do you currently do to relax, to relieve stress or tension? _____

Have you ever had bodywork/massage done before? If so, for what reason (e.g., relaxation, pain relief, physical therapy, etc.)? _____

When was your last massage? _____

What type of pressure do you usually prefer? (please circle) light medium strong

Is there any other information you feel would be helpful to share with me at this time?
_____
_____

Thank you for your cooperation in completing this form. Please keep me updated on any changes to your medical history. Feel free to use another page if more space is needed for health history.

Mischa Bradford Massage Therapy