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Massageandmovement.org

Client Health History

Name ______________________________ Date of first appointment ____________

Address ______________________________

Home phone ______________________________ Cell / work phone ____________

Email address ______________________________

Emergency contact ______________________________ - # ____________

Date of birth ______________________________

What are you hoping to get from our sessions together? ______________________________

____

____

What is your major area of pain/concern? ____________

When did you first notice it? ____________ What brought it on? ____________

What activities aggravate it? ____________ Is this condition getting better or worse? ____________

Does it interfere with work? ____________ sleep? ____________ recreation? ____________

Do you remember emotional stress occurring at the time of the onset? ____________

What do you believe is going on with you? ____________

What have you done to get relief? ____________

Have you sought a diagnosis? ____________ Diagnosis ____________

By whom? ______________________________

Other areas of pain and/or concern ______________________________

____

What alternative therapies have you experienced? ______________________________

Do you move your body regularly? Primary activities & how often? ______________________________

____

What is your current stress level? (low) 1 2 3 4 5 (high) Is the stress: positive or negative or both?

How many hours do you sleep each night? ____________ Do you usually wake feeling: rested? Tired?
Other? ______________________________

Anxiousness: Often Sometimes Seldom Depressed mood: Often Sometimes Seldom

If possible, please explain the negative emotion you experience most ______________________________

When do you most often feel this emotion? ______________________________

Where are you when you feel this emotion? ______________________________

What is your opinion of yourself? ______________________________

Have you ever been to counseling? ____________ What was your experience? ____________

Is there an unrealized longing in your life? ____________ What is it? ____________

What activities are you involved in outside of work? ______________________________

Hobbies and/or interests ______________________________

Are you taking pain medication or blood thinners, or recently stopped taking them? ______________

Please list any supplements, herbs, vitamins, or other products you are presently taking: ______________

____

Do you have allergies? ______________________________

Previous **broken bones**, including year ______________________________

Previous **surgeries**, including year ______________________________

Other **hospitalizations**, including year ______________________________

Childhood accidents or traumas ______________________________

Have you ever hit or fallen on your **head** or **tailbone**? ______________________________

Did you suffer trauma at birth? ______________________________

Do you or have you ever had an **inguinal hernia**? ______________ Please explain ______________

Do you or have you ever had a **hiatal hernia**? ______________ Explain ______________

Do you have **mesh** in your body? ______________ Where? ______________

Circle any of the following that you are **currently** experiencing. **Underline** any you have had in the past:

- Headaches (migraine, tension, cluster)
- contact lenses
- ringing in ears
- tightness in throat
- loss of smell
- loss of taste
- bad breath
- Asthma
- Dentures
- loss of memory
- face flushed
- shooting pain in head
- head feels too heavy
- tightness in shoulder muscles
- muscle spasms in neck
- grating in neck
- lung or breathing problems
- heart problems
- high or low blood pressure
- varicose veins
- circulatory problems
- blood clots / vein inflammation
- varicose veins
- cold hands
- numb hands or feet
- pains in legs and feet
- pins & needles in legs
- numbness in legs/feet
- spinal problems / injury
- sciatica
- low back ache
- pins & needles in back
- painful intercourse
- painful joints
- swollen joints
- pins & needles in arms & hands
- hepatitis
- kidney problems
- bladder/kidney infection
- painful urination
- frequent urination
- incomplete urination
- constipation
- sore heels
- emotional problems
- depression
- anxiety
- irritability
- fatigue
- allergies
- arthritis, osteoporosis, brittle bones
- anorexia/bulimia
- pregnancy
- diabetes
- fainting spells
- frequent cold or flu
- epilepsy or other seizures
- painful menstruation / cramps
- cancer
- skin disorders, acne, fungus, rash
- sensitivity to oils and lotions

How many times do you urinate per night? ______________

Do you have a history of back injury or trauma? ________ Describe ______________________________

____

Family history of cancer? ___________________ Type? ____

Relationship to you: ____

Please list any serious falls or accidents in childhood or as an adult, especially those that involved your tailbone, back, head, or any whiplash; please explain. ____

____

Rate your interest in sex: high moderate low none

Do you have pain with orgasm? ___________

Do you have, or ever had, difficulty experiencing orgasm? _______________________________

Your Menstrual Pattern:

- ☐ Painful periods
- ☐ Late, early, or irregular
- ☐ Dark, thick blood at onset or end of menstruation
- ☐ Dizziness with period
- ☐ Excessive bleeding (more than one pad per hour)
- ☐ Blood clots during menstruation
- ☐ PMS/Depression with or before period
- ☐ Failure to ovulate regularly
- ☐ Painful ovulation
- ☐ Bloating or water retention with period
- ☐ Heaviness in the lower pelvis as **menses begin**
- ☐ Heaviness in the lower pelvis **during ovulation**

How many days does your period last? _____ Do you experience NO periods at all? _________

Explain ____

Have you experienced a period every two weeks within the past few years? _______________

Have you taken hormone replacement therapy? __________ If so, for how long? ________________

Other signs or symptoms:

Cervical polyps	Uterine infections	Chronic miscarriages	False pregnancies
Mood swings	Difficult menopause	Spotting	Endometriosis
Uterine polyps	Frequent urination	Premature deliveries	Endometritis
Memory loss	Bladder infections	Pelvic inflammation	Sexually transmitted disease
Uterine fibroids	Insomnia	Weak newborn infants	
Depression	Fatigue	Ovarian or breast cysts	

Difficult pregnancy, "incompetent" uterus

Dry vagina with or without menopause

Vaginal yeast conditions / vaginitis

Vaginal discharge ____ (color/how often?) ________

Cancer of the cervix, uterus, bladder, or lower bowel (circle) ____

List any other symptoms not included on list: ______________________________________

How many pregnancies have you had? __________________ Number of deliveries? ________________

Date(s) of deliveries __________________________________ How many children? ________________

Were there any complications? ____

What was the **pregnancy** like for **you**? ____

labor? ____

delivery? ____

Did you nurse your babies? ______________If so, what was your impression of that experience? ________________

____

Have you had any pregnancy loss? ______________________ Have you had any abortions? ______________________

If so, how many and when ____

What medications did **your mother** take when she was pregnant with **you**?____________________________________

Do any of the women in your family suffer from the following (circle):

Fertility issues Menstrual problems Difficult menopause

Cancer Difficult childbirth Heart trouble

Are you currently pregnant?______________ Are you hoping to become pregnant in the future? __________________

Do you now or have you ever had fertility challenges? ____

Are you now or **have you ever** taken birth control pills? ____

When and for how long? ____

If any, what type of birth control methods do you use **currently**? ____

Have you ever used an IUD, Essure, hormonal birth control, or hormonal replacement therapy? (circle)

____

Are you presently or have you recently been under a doctor's care for gynecological problems? Explain ____________

____

Anything else you would like me to know? ____

____