

IN BALANCE THERAPEUTIC MASSAGE AND BODYWORK --- Health History Form

Name: _____ Home Phone: (____) _____

Address: _____ Work Phone: (____) _____

City/State/Zip: _____ Date of Birth: _____

Social Security #: _____ - _____ - _____ Date of Injury/Accident: _____

Height: _____ Weight: _____ Age: _____ Sex: _____ Marital Status: _____

Children at Home: _____ Ages: _____ Any Others Living at Home: _____

Primary Care Physician: _____ City: _____

Are you currently under a Doctor's care? _____ For Pain? _____ Other? _____

If yes, name of Physician: _____ Diagnosis Given: _____

Current Treatment(s): _____

Are you here by Referral? : _____ If yes, by whom? _____

Check those Physicians and/or Health Care Professionals you have contacted for your Symptoms:

General/Family Physician _____ Neurologist _____ Orthopedist _____ Osteopath _____

Chiropractor _____ Naturopath _____ Physical Therapist _____ Massage Therapist _____

Occupational Therapist _____ Acupuncturist _____ Counselor _____ Psychologist _____

Psychiatrist _____ Biofeedback _____ Other(specify) _____

List Past Surgeries and Dates: _____

List All Medications You Are Currently Taking Including Over the Counter such as Aspirin, Etc:

	Medication	Dosage	Frequency	Effectiveness
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

List All Vitamins You are Currently Taking: _____

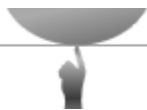
List All Allergies including Food, Medications, Seasonal, Etc: _____

How Much Do You Consume Daily of: Coffee _____ Tea _____ Alcohol _____

Soft Drinks _____ Chocolate _____ Cigarettes/Cigars/Tobacco _____

Are You Allergic to Nuts? Yes No Do You Wear Contact Lenses? Yes No

Are You Nor OR Do You Suspect You Are Pregnant? Yes No



PLEASE CHECK ANY OR ALL THAT APPLY TO YOU:

Right Handed: _____ Left Handed: _____

1. Why Are You Here? Relaxation _____ Injury/Accident _____ Chronic Condition (specify) _____
Other(specify) _____ If You Checked "Relaxation" Only, Skip to Page 4

2. Rate Your Area(s) of Current Pain by Circling the Number on the Scale of "0" (no pain) to "10" (worst pain possible):

Low Back – 0 1 2 3 4 5 6 7 8 9 10

Face – 0 1 2 3 4 5 6 7 8 9 10

Mid Back – 0 1 2 3 4 5 6 7 8 9 10

Right/Left Shoulder – 0 1 2 3 4 5 6 7 8 9 10

Upper Back – 0 1 2 3 4 5 6 7 8 9 10

Right/Left Arm – 0 1 2 3 4 5 6 7 8 9 10

Neck – 0 1 2 3 4 5 6 7 8 9 10

Right/Left Leg – 0 1 2 3 4 5 6 7 8 9 10

Headache – 0 1 2 3 4 5 6 7 8 9 10

Right/Left Hip – 0 1 2 3 4 5 6 7 8 9 10

Other (specify) _____

3. Briefly Describe Your Symptoms and Include When They Began: _____

4. Did These Symptoms Begin as an Injury/Accident? No _____ Yes _____ If Yes, Was it:
On The Job _____ At Home _____ Vehicle Related _____ Seat Belt: On or Off (circle)
Driver _____ Passenger _____ Front or Back Seat (circle) Other (specify) _____
Briefly Describe the Accident _____

(LEAVE THIS BOX BLANK)

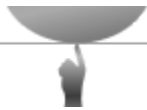
5. What is Your Current Occupation? (NOT Your Employer!) _____

Previous Occupation(s)? _____

6. What Kind of Things or Activities Relieve OR Decrease Your Symptoms? Ice _____ Heat _____
Warm/Hot Bath _____ Exercise _____ Laying Down _____ Activity _____ Sitting _____
Warm/Hot Shower _____ Resting _____ Relaxation _____ Standing _____ Walking _____
Nothing _____ Medications(list) _____ Other (specify) _____

7. What Kind of Things or Activities Increase Your Symptoms? Ice _____ Heat _____ Sitting _____
Warm/Hot Bath _____ Laying Down _____ Activity _____ Exercise _____ Resting _____
Warm/Hot Shower _____ Twisting Movements _____ Standing _____ Waist Bending _____
Walking _____ Reaching or Working Overhead _____ Vacuuming _____ Kneeling _____
Eye Movements _____ Head Movements _____ Nothing _____ Other(specify) _____

8. Describe the Pattern of Your Symptoms: Constant _____ Periodic _____ Transient _____
Worse on Walking _____ Worse Near the End of the Day _____ Sharp _____ Stabbing _____
Pounding _____ Fearful _____ Dull/Achy _____ Tingling _____ Throbbing _____ Tight _____
Shooting _____ Hot/Burning _____ Tender _____ Suffocating _____ Radiating _____
Other (specify) _____



9. Check Any Other Symptoms You Are Experiencing? Shooting Pains _____
 Headaches _____ Diarrhea _____ Constipation _____ Weight Gain _____ Depression _____
 Nausea _____ Clenching of Teeth _____ Tiredness/Fatigue _____ Shortness of Breath _____
 Pounding/Racing of Heart _____ Dizziness _____ Allergies _____ Sexual Dysfunction _____
 Stiffness _____ Limited Range of Movement _____ Sleeping Changes (more or less) _____
 Weight Loss _____ Anxiety _____ Other (specify) _____

10. Check Any Previous Injuries/Accidents in Which You have Been Involved:

Track _____	Falling _____	Bicycle _____	Horseback Riding _____
Football _____	Slipping _____	Motorcycle _____	Roller/Ice Skating _____
Baseball _____	Tripping _____	Car _____	Snow/Water Skiing _____
Basketball _____	Stumbling _____	Truck _____	Bumping/Hitting Head _____
Volleyball _____	Stubbing _____	Bus _____	Childhood (specify below) _____
Soccer _____	Jamming _____	Other Vehicle _____	Other (Specify below) _____

(LEAVE THIS BOX BLANK)

IF HEADACHES ARE YOUR MAIN AREA OF COMPLAINT OR HAVE BECOME FREQUENT SINCE YOUR SYMPTOMS BEGAN, CHECK ALL THOSE WHICH APPLY TO YOU IN QUESTIONS 11-15.

<p>11. How Often Do You Get Headaches?</p> Daily _____ Every Other Day _____ Once a Week _____ Twice a Month _____ Once a Month _____ Sporadically _____ Rarely _____	<p>12. How Long Do the Headaches Last?</p> Hours (specify) _____ One Day _____ Two Days _____ Three Days _____ Four Days _____ Longer Than Four Days _____ They Never Go Away _____
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13. Describe Where in Your Body You FIRST Feel Your Headache:

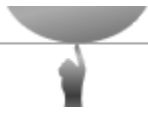
Mid Back _____ Upper Back/Shoulders _____ Neck _____ Jaw _____ Eyes (behind/side) _____
 Forehead _____ Right or Left Ear _____ Other (specify) _____

14. How Would You Describe Your Headache:

Pressure From the Inside Pushing Outward _____ A Vice Around Your Head _____
 Bright Lights Followed by Extreme Pain _____
 Pressure Pushing on Left or Right Side of Face _____ Earache/Infection _____
 Forehead Pressure _____ Other (specify) _____

15. What Time of Day Do You FIRST Notice Your Headache?

Upon First Waking _____ After Getting Out of Bed _____ Mid Morning _____ Noon _____
 Early Afternoon _____ Late Afternoon _____ Early Evening _____ Late Evening _____



16. Please Check of List Any Conditions or Symptoms For Which You Have Been or are Currently Being Treated:

Skin Conditions:

- Eczema _____
- Cancer _____
- Herpes _____
- Psoriasis _____
- Acne _____
- Bruises _____
- Other (specify) _____

Respiratory Conditions:

- Asthma _____
- Bronchitis _____
- Collapsed Lung _____
- Lung Disease _____
- Pulmonary Embolus _____
- Other (specify) _____

Nervous System Conditions:

- Multiple Sclerosis _____
- Neuralgias _____
- Pinched Nerve _____
- Neuritis _____
- Sciatica _____
- Other (specify) _____

Circulatory Conditions:

- Phlebitis _____
- Blood Clots/DVT _____
- Varicosities _____
- High/Low Blood Pressure _____
- Heart Disease _____
- Pacemaker _____
- Angina _____
- Stroke _____
- High Cholesterol _____
- Other (specify): _____

Digestive/Urinary Conditions:

- Ulcer _____
- Colitis _____
- Irritable Bowel _____
- Bladder Infection _____
- Kidney Infection/Stone _____
- Chronic Renal Failure _____
- Liver Disorder _____
- Chronic Constipation/ Diarrhea _____
- Gall Bladder _____
- Other (specify): _____

Muscular/Tendon Conditions:

- Sprain _____
- Strain _____
- Tendinitis _____
- Fibromyalgia _____
- Chronic Stiffness _____
- Leg Cramps _____
- Muscle Imbalance or Weakness _____
- Limited Movement _____
- Other (specify): _____

Osteopathic Conditions:

- Broken Bones _____
- Osteoporosis _____
- Osteoarthritis _____
- Degenerative Hip, Shoulder, or Knee _____
- Other (specify) _____

Lymphatic Conditions:

- Virus Cold _____
- Virus Flu _____
- Lymphangitis _____
- Swollen Lymph Nodes _____
- Other (specify): _____

Please Check Any Other Conditions

- | | | |
|----------------|-------------------|--------------------------------------|
| Polio _____ | HIV+ _____ | Arthritis _____ |
| Cancer _____ | AIDS _____ | Tuberculosis _____ |
| Ulcers _____ | PMS _____ | Heart Disease _____ |
| Anemia _____ | TMJ _____ | High or Low Thyroid _____ |
| Stroke _____ | Gout _____ | Chronic Sinus Infections _____ |
| Asthma _____ | Alcoholism _____ | Dizziness or Fainting Spells _____ |
| Bursitis _____ | Emphysema _____ | Nipple Tenderness or Discharge _____ |
| Diabetes _____ | Weight Loss _____ | Other (specify): _____ |
| Epilepsy _____ | | |