Client Health History

Name:_____ Birthday:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone (Day):_____ Evening:_____

Email Address:_____

Occupation and Place of work: _____

Emergency Contact Person and Telephone Number:_____

Please circle Y (yes) or N (no) for the following questions:

Have you received a massage before? Y N

Are you currently under Doctors Care? Y N If yes, for what reason?_____

_____

Have you been under Doctor Care in the last 12 months (other than listed above)? Y N

If yes, for what reason?_____

Have you been tested for COVID-19? If so what were the results and when were you tested?_____

Are you currently under Chiropractic care? Y N

Are you currently taking a prescribed medication? Y N If yes, please name the medication and the condition for which the medication is prescribed _____

_____

Have you had surgery in the last four months? Y N If yes, why?_____

_____

Have you been hospitalized in the last four months? Y N If yes, why?_____

_____

Are you pregnant? Y N Have you been pregnant in the last four months? Y N

Do you currently wear contacts? Y N

Have you had a Fever in the last 24 hours? Y N If yes, the temperature?_____

Please Circle any item that causes you to have an allergic reaction: Peppermint, Pine, Seaweed, Scented Oil, Shellfish, Scented lotion, Nuts, Iodine, Eucalyptus, Oil

Please list any topical or internal allergies that you may have:_____

Please circle **C** for Current conditions and **P** for Previous conditions. Do not circle conditions which do not apply to you.

Heart Disease	C	P	Diabetes	C	P
High Blood Pressure	C	P	Cancer/Tumors	C	P
Low Blood Pressure	C	P	HIV virus	C	P
Varicose Veins	C	P	Multiple Sclerosis	C	P
Blood Clotting	C	P	Disc Condition	C	P
Stroke Date:_____	C	P	Medicated Depression	C	P
Circulatory disorder	C	P	Thyroid Imbalance	C	P
Heart Condition What:_____	C	P	Hearing Problems	C	P
Pacemaker	C	P	Claustrophobic	C	P
Asthma	C	P	Headaches/Migraines	C	P
Abdominal/Digestion problems	C	P	Dizziness	C	P
Hernia	C	P	Tendonitis	C	P
Heat Sensitivity	C	P	Numbness	C	P
Fragile Skin	C	P	Chronic Pain	C	P
Hypersensitive Skin	C	P	Where:_____		
Eczema	C	P	Sprains/Strains	C	P
Skin Disease What:_____	C	P	Where:_____		
Blisters	C	P	Arthritis	C	P
Rash	C	P	Where:_____		
Athlete's foot	C	P	Edema/Swelling	C	P
MRSA	C	P	Where:____		
Epilepsy/Seizures	C	P	Injury Date:_____	C	P
Communicable Disease	C	P	Fibromyalgia	C	P

Client Signature:_____ Date:_____