



Health History

Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____
Email address: _____
(for internal use only)
Occupation: (past or present) _____
Emergency Contact: Name _____ Relationship _____
Phone _____ Alternate Phone _____
Whom may we thank for your referral? _____

Primary Physician: _____ Phone number: _____
Specialist: _____ Phone number: _____

Are you under the care of any of the following? (Check all that apply):

- Medical Doctor (MD)
- Psychiatrist/Psychologist
- Personal Trainer
- Osteopath
- Physical Therapist
- Nutritionist
- Dentist
- Chiropractor
- Massage Therapist

If you have seen any of the above in the past three months, briefly describe the reason (illness, medical condition, physical, etc.): _____

Please describe the reason you are seeking treatment or any significant medical history (surgeries,, physical or emotional trauma, accidents)

Please list any significant family history _____

List any PRESCRIPTION medications you are taking: (prescription or OTC)

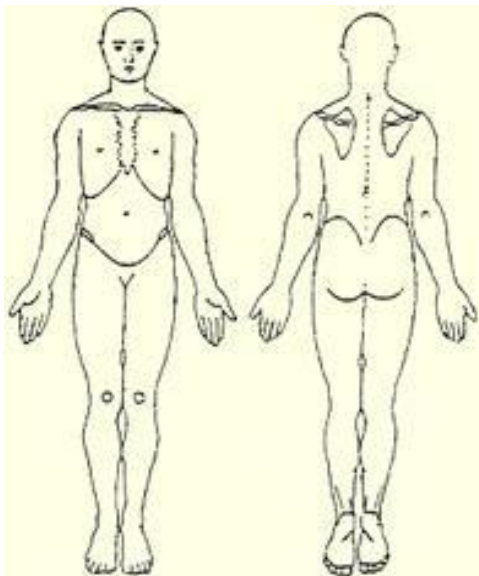
- 1. _____ 2. _____ 3. _____ 4. _____

What would a successful outcome look like to you?

Short Term _____

Long Term _____

Please indicate symptoms you are currently experiencing on the diagram below:



Do your symptoms make it difficult for you to sleep well? YES NO
(circle all that apply)

Difficulty falling asleep

Waking up due to pain

Difficulty returning to sleep

Describe any positions that make symptoms worse;

Sitting Standing Squatting Bending Twisting

Reaching overhead

Other _____

Describe any positions that make symptoms better;

Sitting Standing Walking or movement Laying down

Other _____

Women: Are you (or could you be) pregnant? _____

Number of children: _____ Vaginal or Caesarian birth? (circle)

Is there anything that hasn't been listed that your therapist should know? _____

I understand the relationship I have with my myofascial release therapist is a partnership. I have the right to ask questions regarding my treatment as well as refuse any part of treatment that has been recommended. My signature gives my consent to be treated.

Patient Name

Signature

Date