



Health History Form

Name: _____ Phones: evening _____ other _____
 Address: _____ Age: _____ Birthdate: _____
 City/State/Zip: _____ Email: _____

The following form is thorough because all components of your health can affect the health of your tissues and structure. Additionally, having a detailed and comprehensive understanding of your health allows us to help our clients figure out what other activities, behaviors, or choices you can explore outside of our sessions to support your health.

Please check the musculoskeletal conditions that you currently experience or have experienced in the past:

<u>Current</u>	<u>Past</u>	<u>Connective Tissue / Bone / Muscle Conditions</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	which joint(s) _____
<input type="checkbox"/>	<input type="checkbox"/>	Bulging/herniated disc	which vertebra(e) _____
<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	which joint(s) _____
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	diagnosed at what age _____
<input type="checkbox"/>	<input type="checkbox"/>	Hernia	hiatal <input type="checkbox"/> abdominal <input type="checkbox"/> inguinal <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Joint stiffness/swelling	which joints _____
<input type="checkbox"/>	<input type="checkbox"/>	Muscle spasms/cramps	which muscles _____
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	diagnosed at what age _____
<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	right <input type="checkbox"/> left <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	diagnosed at what age _____
<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis	which joints _____

<u>Current</u>	<u>Past</u>	<u>Pains of Joints and Areas</u>	<u>Location</u>	<u>Suspected cause of pain (i.e., injury, work setup, repetitive activities, etc.)</u>
<input type="checkbox"/>	<input type="checkbox"/>	Chronic headaches/ migraines	area(s) of regular pain _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain/TMJ	right <input type="checkbox"/> left <input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	right <input type="checkbox"/> left <input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Upper back	right <input type="checkbox"/> left <input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder pain	right <input type="checkbox"/> left <input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Elbow pain	right <input type="checkbox"/> left <input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Wrist/hand pain	right <input type="checkbox"/> left <input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chest/ribs/abdominal pain	right <input type="checkbox"/> left <input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Lower back	right <input type="checkbox"/> left <input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hip pain	right <input type="checkbox"/> left <input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Leg pain	right <input type="checkbox"/> left <input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Knee pain	right <input type="checkbox"/> left <input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/foot pain	right <input type="checkbox"/> left <input type="checkbox"/>	_____

Please check the health conditions that you currently experience or have experienced:

<u>Current</u>	<u>Past</u>	<u>Energy / Mood / Nervous System</u>
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Brain fog/difficulty concentrating
<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/fainting/balance issues
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems
<input type="checkbox"/>	<input type="checkbox"/>	insomnia <input type="checkbox"/> can't stay asleep <input type="checkbox"/> other
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease

<u>Current</u>	<u>Past</u>	<u>Digestion</u>
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
		<input type="checkbox"/> chronic <input type="checkbox"/> occasional
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
		<input type="checkbox"/> chronic <input type="checkbox"/> occasional
<input type="checkbox"/>	<input type="checkbox"/>	Food allergies
<input type="checkbox"/>	<input type="checkbox"/>	Food cravings
		what foods _____
<input type="checkbox"/>	<input type="checkbox"/>	Regular stomachaches
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Other digestive issues

<u>Current</u>	<u>Past</u>	<u>Kidneys / Lymph</u>
<input type="checkbox"/>	<input type="checkbox"/>	Bladder/kidney infections
		year of last infection _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	Edema/fluid retention
		what area of the body _____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic swollen lymph nodes

<u>Current</u>	<u>Past</u>	<u>Illnesses</u>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/tumor
		kind _____ year _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Ear infections
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	Sinus infections

<u>Current</u>	<u>Past</u>	<u>Respiration</u>
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/respiratory problems
<input type="checkbox"/>	<input type="checkbox"/>	Inhalant allergies/hay fever

<u>Current</u>	<u>Past</u>	<u>Heart / Blood</u>
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/clotting disorder
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cold hands or feet
<input type="checkbox"/>	<input type="checkbox"/>	Chronic venous insufficiency
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack
		what year _____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/blood clots/varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
		what year _____
<input type="checkbox"/>	<input type="checkbox"/>	Other heart condition

<u>Current</u>	<u>Past</u>	<u>Skin</u>
<input type="checkbox"/>	<input type="checkbox"/>	Athlete's foot
<input type="checkbox"/>	<input type="checkbox"/>	Brittle nails
<input type="checkbox"/>	<input type="checkbox"/>	Dry skin/itchiness
<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	Scleroderma

<u>Current</u>	<u>Past</u>	<u>Reproductive</u>
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	Infertility
<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy
		<input type="checkbox"/> partial <input type="checkbox"/> full
<input type="checkbox"/>	<input type="checkbox"/>	Low libido
<input type="checkbox"/>	<input type="checkbox"/>	Peri-/menopausal symptoms
		what symptoms _____
<input type="checkbox"/>	<input type="checkbox"/>	PMS symptoms
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
		# of pregnancies ____ # of live births ____
		<input type="checkbox"/> vaginal delivery <input type="checkbox"/> Caesarean
<input type="checkbox"/>	<input type="checkbox"/>	Other reproductive issues
Additional Reproductive Questions for Women:		
Average length of your cycle _____ days		
Average length of menstruation _____ days		
Are you trying to conceive? yes <input type="checkbox"/> no <input type="checkbox"/>		
Do you have an IUD? yes <input type="checkbox"/> no <input type="checkbox"/>		

Any additional symptoms or illnesses not mentioned above: _____

Traumas - injuries, accidents, and surgeries (please include approximate year or age of trauma):

_____ abdominal surgery, _____ appendectomy, _____ bike accident, _____ birth trauma, _____ broken or dislocated bones _____ car accident, _____ concussion, _____ falls, _____ joint replacement surgery, _____ labor/delivery trauma, _____ pulled or torn muscles, _____ root canals or other major dental work, _____ sprains, _____ tonsillectomy, _____ verbal/physical/sexual abuse, _____ other surgeries or accidents

Additional details about these traumas: _____

Medications and Supplements

Medications For what condition Haven taken for how long

Medications	For what condition	Haven taken for how long

Supplements (vitamins, minerals, etc.) _____

Diet

Do you consume the following: Every day Most days Occasionally Never, I avoid this?

Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peanuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premade meals (e.g., frozen dinners, boxed dinners, canned soups)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Condiments (e.g., ketchup, soy sauce, salad dressing, mayo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fried foods (e.g., chips, crackers french fries, doughnuts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restaurant meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fast food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other foods you avoid, such as salt or other allergens: _____

Do you follow a particular diet (i.e., gluten-free, vegan, Paleo Diet, etc.)? _____

	Yes	No	If yes, how many / how often
Caffeinated coffee, tea, or soda	<input type="checkbox"/>	<input type="checkbox"/>	_____ cups or cans / day, week, month
Diet soda	<input type="checkbox"/>	<input type="checkbox"/>	_____ cups or cans / day, week, month
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____ drinks / day, week, month
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	_____ cigarettes / day, week, month

If yes, for how many years? _____

How much water do you drink daily? _____

Physical Habits

Are you right-handed or left-handed ?

How do you sleep? On your: side back stomach On average, I sleep _____ hours per night.

Do you wear glasses or contacts? Yes No

Do you sit on your wallet regularly? Yes No

Do you wear shoes with elevated heels: 1-7 times a week 1-4 times a month rarely/never ?

How would you rate your general energy? Very good Good Fair Poor Very poor

On a scale of 1 to 10 (1 = lowest), what is the amount of stress/tension in your life? 1 2 3 4 5 6 7 8 9 10

Do you exercise regularly? Yes No

If so, what type of exercise and how often? _____

Occupation _____

Have you received a massage or bodywork before? Yes No If so, how recently? _____

Reason for today's visit: _____

What is going well in your life? _____

Primary care physician _____ Other health care provider _____
(e.g., medical specialist, chiropractor, acupuncturist)

In case of an emergency, contact: Name _____ Telephone _____

If you were referred to our office, who referred you? _____

The information above is complete and accurate to the best of my knowledge. I understand that bodywork therapy and acupuncture do not take the place of physicians' services. The work and information that I receive during a session is for the purposes of improving my general health. I will keep the therapist informed of any changes in my health as they occur.

This health history form may be viewed by the therapist(s) at Kinetikos with whom I schedule sessions. If I see more than one practitioner at Kinetikos, I do do not allow them to share their session notes and other information about my health with each other.

My signature below indicates that I understand and agree to the above conditions.

Signature _____ Date _____

Additional information:

- The benefits of bodywork can be more readily received when you are comfortable, so please let us know if elements of your session are not comfortable for you.
- For Rolfing and Lymph Drainage Therapy sessions, clients usually wear underclothing. During massage appointments, clients are draped with a sheet.
- All details of a client's session are private and confidential.
- If you must miss a scheduled appointment, we ask that you cancel your appointment 24 hours in advance.
- Sessions that begin late due to the client's having arrived late end at the appointed time and are full price.
- Payment is expected at the time service is rendered. We accept personal cash, checks, and credit cards.
- This is a scent-free office. Please refrain from wearing perfume or cologne to your appointment.