CLIENT HEALTH HISTORY

NAME: _____ DATE: _____

This questionnaire will help me give you the best professional care and service. Your information contained herein will be kept in strict confidence.

Mailing address: _____

E-mail address: _____

E-mail reminders are sent automatically from Genbook 24 hours before your scheduled appointment. I also send out occasional e-mails informing clients of specials and discounts. You can request to be removed from the e-mail list at any time.

Phone: (primary) _____ (secondary) _____

It is acceptable to call between the hours of _____a.m. and _____p.m.

Date of Birth: _____ Age: _____ Occupation: _____

Referred by: _____ May I let the referrer know you came in today so they can receive a referral discount? If yes, please initial to give permission: _____

Emergency contact: _____ Phone: _____

Do you wear contacts? _____ Dentures? _____ Are you pregnant? _____ If so, how many months? _____

Are you involved in any other therapy at this time? If so, what, and how often?

_____

Are you currently taking medications? Please list medications, dosages, and what they are treating:

_____

_____

Do you have any current known: (Elaborate if checked.)

_____ injuries _____
_____ bruises _____
_____ infections _____
_____ contagious diseases _____
_____ allergies or sensitivities (food, inhalants or smells, detergents, latex, etc.)
_____

Do you have any of the following?

_____ high blood pressure
_____ low or irregular blood pressure
_____ known blood clots
_____ arthritis or bursitis
_____ heart problems
_____ kidney problems
_____ emotional sensitivities
_____ degenerated discs

List any previous injuries (broken bones, severe sprains, whiplash, traumas, etc.) and surgeries. Continue on a separate sheet, if needed.

_____ Date: _____

_____ Date: _____

_____ Date: _____

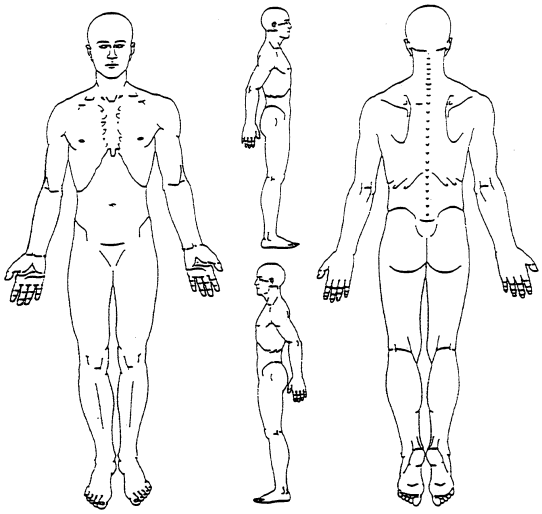
_____ Date: _____

With which hand do you write? (Circle one) L R

Do you feel as if you "hold" stress or tension in any part of your body? (Circle one) YES NO
Do you experience any of the following:

_____ chronic headaches _____ bruxism (clenching, grinding of the teeth)
_____ chronic backaches _____ tightness in the jaw (especially upon waking)

On the diagram below, please circle the areas that best correspond to the places where you feel you hold stress, tension, or those areas where you are currently experiencing discomfort or pain.



What type(s) of exercise or activities do you do? How often?

_____

How would you describe your dietary habits?

_____

Approximately how many ounces of water do you drink per day *(not including soda, coffee, or tea*)? _____

What do you currently do to relax, to relieve stress or tension?

_____

Have you ever had bodywork/massage done before? If so, for what reason (relaxation, pain relief, physical therapy, etc.), and when? _____

What type of pressure do you usually prefer? _____ light _____ medium _____ heavy

Is there any other information you feel would be helpful to share with me at this time?

_____

_____

Thank you for your patience in completing this form. Please keep me updated on any changes to your medical history.