

Health History

Disclosure of health information will enable the practitioner to adapt massage therapy and/or yoga to your needs. Your health information is private and will be regarded in strict confidentiality and in accordance with HIPAA regulations. Check any conditions that apply to you, past and present. Where appropriate, add comments to help clarify the nature of your condition(s).

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| <p>Musculo-Skeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Joint stiffness/swelling <input type="checkbox"/> Spasms/cramps <input type="checkbox"/> Broken/fractured bones <input type="checkbox"/> Strains/sprains <input type="checkbox"/> Back, hip pain <input type="checkbox"/> Shoulder, neck, arm, hand pain <input type="checkbox"/> Leg, foot pain <input type="checkbox"/> Chest, ribs, abdominal pain <input type="checkbox"/> Problems walking <input type="checkbox"/> Jaw pain/TMJ <input type="checkbox"/> Tendinitis <input type="checkbox"/> Bursitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Bone or joint disease <p>Circulatory and Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dizziness <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Fainting <input type="checkbox"/> Cold feet or hands <input type="checkbox"/> Cold sweats <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Pressure sores <input type="checkbox"/> Varicose veins <input type="checkbox"/> Blood clots <input type="checkbox"/> Stroke <input type="checkbox"/> Heart condition <input type="checkbox"/> Allergies <input type="checkbox"/> Sinus problems <input type="checkbox"/> Asthma <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Lymphedema | <p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rashes <input type="checkbox"/> Allergies <input type="checkbox"/> Athlete's Foot <input type="checkbox"/> Warts <input type="checkbox"/> Moles <input type="checkbox"/> Acne <input type="checkbox"/> Cosmetic surgery <p>Digestive</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nervous stomach <input type="checkbox"/> Indigestion <input type="checkbox"/> Constipation <input type="checkbox"/> Intestinal gas/bloating <input type="checkbox"/> Diarrhea <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Colitis <input type="checkbox"/> Adaptive aids <p>Nervous System</p> <ul style="list-style-type: none"> <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Twitching of face <input type="checkbox"/> Fatigue <input type="checkbox"/> Chronic pain <input type="checkbox"/> Sleep disorders <input type="checkbox"/> Ulcers <input type="checkbox"/> Paralysis <input type="checkbox"/> Herpes/shingles <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Epilepsy <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Spinal cord injury | <p>Reproductive</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pregnancy: (Current/Previous) <input type="checkbox"/> PMS <input type="checkbox"/> Menopause <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Endometriosis <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Fertility concerns <input type="checkbox"/> Prostate problems <p>Other</p> <ul style="list-style-type: none"> <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Confusion <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Drug use _____ <input type="checkbox"/> Alcohol use _____ <input type="checkbox"/> Nicotine use _____ <input type="checkbox"/> Caffeine use _____ <input type="checkbox"/> Hearing impaired <input type="checkbox"/> Visually impaired <input type="checkbox"/> Burning upon urination <input type="checkbox"/> Bladder infection <input type="checkbox"/> Eating disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Post/Polio Syndrome <input type="checkbox"/> Cancer <input type="checkbox"/> Infectious disease (please list)
_____ <input type="checkbox"/> Other congenital or acquired disabilities (please list) _____
_____ <input type="checkbox"/> Surgeries _____ <input type="checkbox"/> Herbs, Supplements or natural remedies
<input type="checkbox"/> Pharmaceutical Drugs |
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*Additional comments:

I have stated all conditions that I am aware of and affirm that this information is true and accurate. I will inform the health care provider of any changes in my health status.

Signature: Date: