body | balance realign. reconnect. recover.

Confidential Health History

Name: ______________________________ Today's Date: ____________

Address: ____
Number Street City State Zip

Date of Birth: ________________ Marital Status: ____________ Number of Children: ________

Gender identity/preferred pronoun(s): ______________________________

Primary Phone: ______________________ Home Cell Work Preferred

Secondary Phone: ______________________ Home Cell Work Preferred

Emergency Contact: ______________________ Phone: ______________________

Email: ____

Only for occasional communication from our office, circle one: Opt IN Opt OUT

Occupation: ______________________ Employer: ______________________

What do you
Physically do at work? ______________________________

Pregnant or
nursing now? ____________ Miscarriages or
terminations and dates: ______________________

Dentures or
Dental appliances? ______________ Orthotics or inserts
in your shoes? ______________________

Most recent massage
or Rolfing session: ______________________ Who may we thank
for referring you? ______________

Primary physician: ______________________________
Name Phone number

If you are currently being treated by a doctor for something specific, please explain and give doctor's name and specialty: ______________________________

____

Please list ALL medications and supplements you are currently taking and why: ______________

____

____

List all previous injuries, injections, and surgeries and give approximate dates: ______________

____

____

Exercise (Types and Frequency): ______________________________

____

Caffeine: Quantity____________________ Frequency__________________

Alcohol: Quantity____________________ Frequency__________________

Tobacco: Quantity____________________ Frequency__________________

Sugar: Quantity____________________ Frequency__________________

Water: Quantity____________________ Frequency__________________

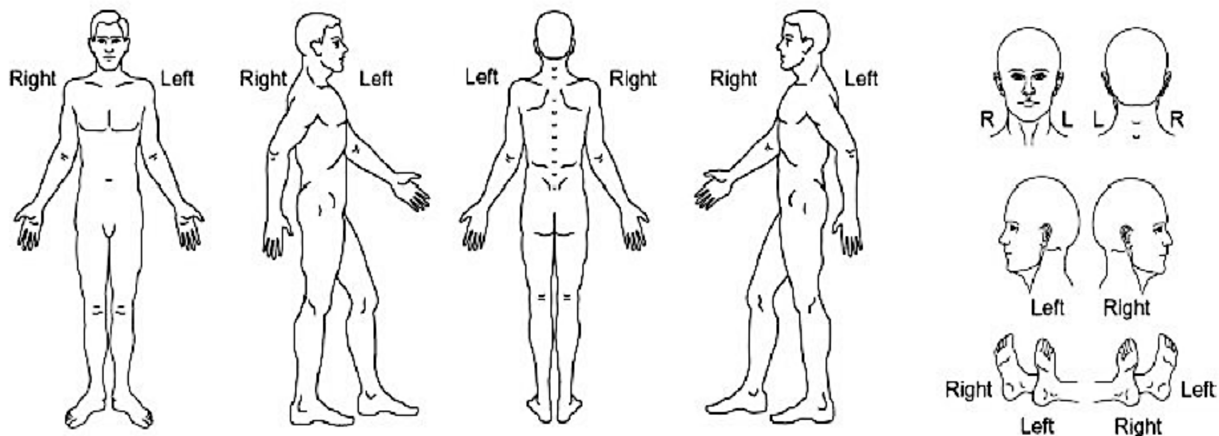
If you have pain: When did it start? What caused it? Where is it? How often do you feel it? On a 1-10 scale (10 being highest), indicate the location(s), intensity, & type of pain (dull, sharp, deep, superficial, shooting, tingling, burning etc.):): ____

____

____

What do you do for pain management?): ____

Please SHADE ALL AREAS PAIN, DISCOMFORT, AND STIFFNESS, regardless of severity:



Please CHECK all areas of pain, injury, or health condition that apply:

Headaches	Joint pain/ immobility	Skin problems	Varicose veins
Neck	Numbness/tingling	Arthritis or bursitis	Open sore/wound
Shoulder	Muscular cramps	Depression	MS or CP
Upper back	TMJ dysfunction	Stress	Phlebitis/history of blood clots
Mid back	Night guard/splint	Sleeping difficulties	Contagious health/skin condition
Low back	Scoliosis	Nervousness/anxiety	Implants – type/location
Hip	Sciatica	Menstrual problems	
Leg/knee	Fibromyalgia	Diabetes	
Ankle/foot	Constipation	Cancer/tumors	Other health condition(s) (please list)
Arm/hand/wrist/fingers	Allergies	Heart disease	