HEALTH HISTORY FORM Date: ____/____/____

Health Enhancement Therapies, 205 County Road 119, Saint Michael, MN 55376
PH: 612-716-6199 / FAX: 763-420-5562

First Name: _____ M.I. _____ Last Name: _____

Address: _____ _____

City:_____ State: _____ Zip _____

Occupation_____Date of Birth:_____

Phone(h)_____(w)_____(mobile) _____

e-mail:_____Referred by: _____

Emergency contact:_____ Phone: _____Relationship: _____

Is this your first professional massage? _____ If no, how frequently do you get a massage? _____

What do you hope to accomplish from today's massage? _____

Describe any surgeries, hospitalizations, accidents or injuries you have had: _____

_____

Do you have any chronic, ongoing pain that you deal with on a regular basis? _____

explain: _____

Activities that cause this pain and/or make it worse: _____

Are you receiving any other type of medical treatment? Yes____ No ____ Explain:_____
Type of treatment and Provider's info

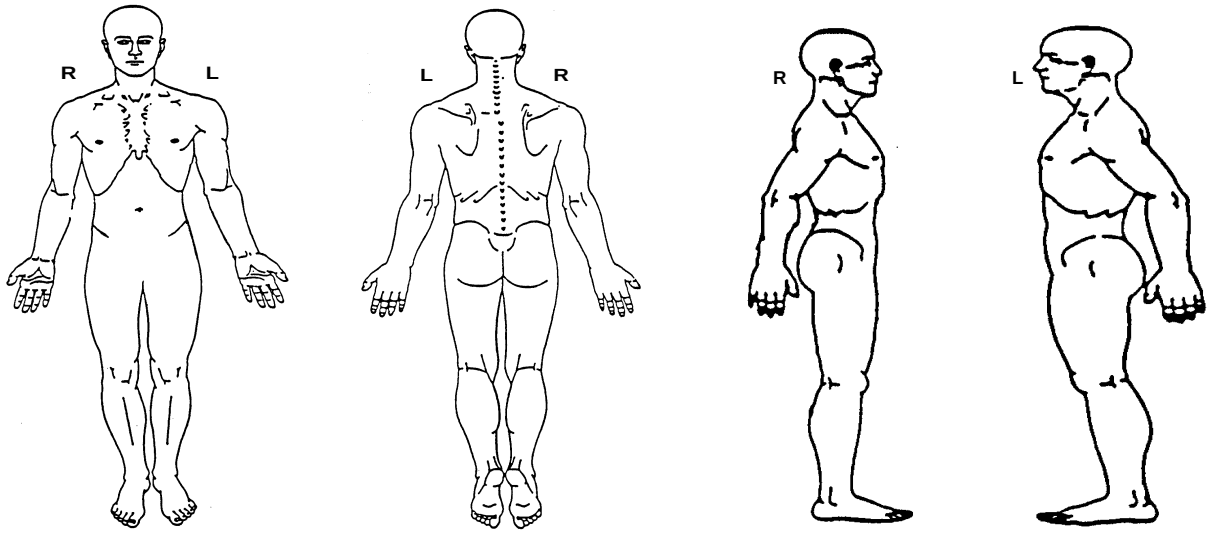
_____

List any medications currently taking (& what it is used to treat): _____

_____

Other activities/hobbies do you participate in _____

Please indicate areas of pain or concern on the drawing below:



Please check any of the following conditions below that currently affect you or that you have recently experienced.

MUSCULOSKELETAL
___ Fibromyalgia
___ Spasms/Cramps
___ Sprains/Strains
___ Fractures
___ Osteoporosis
___ Postural Deviations
___ Gout
___ Osteoarthritis/Rheumatoid Arthritis
___ TMJ
___ Cysts
___ Bursitis
___ Plantar Fasciitis
___ Tendonitis
___ Torticollis
___ Whiplash Syndrome
___ Carpal Tunnel Syndrome
___ Sciatica
___ Thoracic Outlet Syndrome
___ Headache
___ Neck Pain
___ Leg Pain
___ Arm Pain/Shoulder Pain
___ Low Back Pain
___ Mid Back Pain
___ Upper Back Pain
___ Hip Pain
___ Other _____

RESPIRATORY
___Cold or Flu (at the present time?)
___ Pneumonia
___ Sinusitis
___ Asthma
___ Trouble Breathing
___ Dizziness
___ Other_____

CIRCULATORY
___ Anemia
___ Hemophilia
___ Hypertension
___ Low Blood Pressure
___ Reynaud's Disease
___ Varicose Veins
___ Heart Condition
___ Blood Clots/Phlebitis
___ Diabetes
___ Other _____

DIGESTIVE
___ Ulcers
___ Irritable Bowel Syndrome
___ Colitis
___ Gallstones
___ Hepatitis
___ Crohn's Disease
___ Diarrhea
___ Gas/Bloating
___ Indigestion
___ Other _____

SKIN
___ Fungal Infections
___ Acne
___ Impetigo
___ Dermatitis/Eczema
___ Hives/Shingles
___ Psoriasis
___ Open Wound or Sore
___ Rashes
___ Warts/Moles
___ Athletes Foot
___ Other _____

NERVOUS SYSTEM
___ ALS
___ Multiple Sclerosis
___ Parkinson's Disease
___ Bell's Palsy
___ Neuritis
___ Spinal Cord Injury
___ Stroke
___ Trigeminal Neuralgia
___ Seizure Disorders
___ Numbness/Tingling/Twitching
Where? _____
___ Other _____

OTHER
___ Insomnia
___ Anxiety/Panic Attacks
___ PMS
___ Grief Process
___ Cancer
___ Substance Abuse
___ Pregnancy
___ Chronic Fatigue
___ HIV/AIDS
___ Lupus
___ Kidney Disease
___ Bladder Infection
___ Postoperative Situation
___ Edema
___ Other _____

___ Do you smoke?

___ Do you drink caffeine?
Amount? _____

____Sensitivities to scents/ oils?

_____

(CIRCLE ONE)
COVID-19 VACCINATION? YES / NO DATE OF 2ND DOSE: _____

Doctor's Name_____Clinic_____

Address: _____PH: _____

- *The above information is accurate and true to the best of my knowledge. I understand that massage therapy is a health aid and not a substitute for medical care or examination. Information exchanged during a session is intended to help with health status awareness and is to be used at my own discretion.*
- *I am responsible for informing therapist of any physical, mental or emotional changes in my health.*
- ***I also understand that cancelled or missed appointments without 24 hour notice (medical emergencies excluded) may be charged in full for the price of the missed session.***
- ***I understand close proximity increases risk of exposure to contagions, including Covid-19, and have read and agree with the above and hereby release therapist of any liability.***

Signature: _____ **Date:** _____
Client

Guardian: _____ _____
Signature of parent or guardian required if under 18 Printed Name and relationship to client