Doshi Wellness

CONFIDENTIAL PATIENT HEALTH HISTORY

Name:_____Email:_____

Address:_____ City, State & Zip:_____

Phone:_____ Date of Birth:_____

Occupation:_____ Marital Status:_____

Emergency Contact:_____Phone:_____

Have you had a professional massage?_____If yes, when was your last massage?_____

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

Are you aware of any tension holding spots in your body?_____ If yes, location (s) _____

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

Less than 5 years ago:_____

More than 5 years ago:_____

Please list ANY known allergies:_____

Do you have any hardware in your body?_____ If yes, location(s)_____

Do you have any chronic, ongoing pain that you deal with regularly?_____ Please explain:_____

_____

Describe what activities cause pain and/or make it worse:_____

Are you currently receiving any type of medical treatment?_____

Please list any medication (vitamins, herbs or pharmaceutical) that you are currently taking:_____

_____

I use essential oils in my sessions. Do you have any aversion to aromatherapy?_____

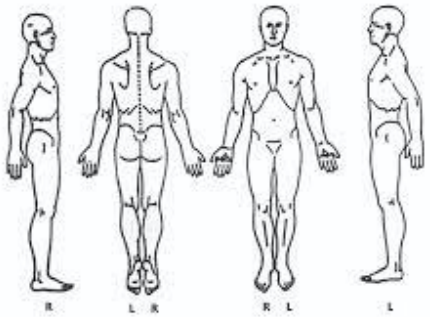
What are your favorite smells?_____

On a scale of zero (least) to ten (most), what is your average stress level:_____

How many hours a night do you sleep soundly?_____

Do you smoke?_____ Circle: Are you Right-hand or Left-hand dominant?

Check any of the following conditions below that **currently** affect you and indicate where you are experiencing pain.



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

RESPIRATORY
___ Pneumonia
___ Sinusitis
___ Asthma
___ Trouble Breathing
___ COPD

CIRCULATORY
___ Anemia
___ Hemophilia
___ Hypertension
___ Low Blood Pressure
___ Raynaud'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
___ Psoriasis
___ Open Wound or Sore
___ Rashes
___ Warts/Moles
___ Athletes Foot

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

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

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I also understand that canceled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature: _____ Date: _____