Confidential Patient Information

Name: _____ Date: _____

Address: _____ Phone (Hm): _____

City/State/Zip: _____ Phone (Cell): _____

Birth Date: _____ Phone (Work): _____ email: _____

Physician: _____ Phone: _____

Your Occupation: _____ Hobbies:_____

Emergency Contact: _____ Phone:_____

How did learn about this practice?

What are your goals for manual and massage therapy care?

Please describe your problem(s):

Problem	**Describe Symptoms (achy, sharp, etc)**	**Cause if known**	**How long a problem?**

What makes this problem better and worse?

Improves	**Worsens**

What treatment have you received for your problem?

Treatment	**Results**

List any injuries (including car accidents), surgeries, and hospitalizations. Include body parts and approximate date:

List current medications and reason for taking, including aspirin, herbal, etc:

CONFIDENTIAL HEALTH HISTORY

Name_____ Today's Date_____
Birth Date _____Date of last physical examination _____

Check (√) any problems or symptoms you have now or have ever had:

Diabetes
Eye infections
Thyroid disease
Eczema
Hives or rashes
Bronchitis
Emphysema
Hepatitis
Pneumonia
Pancreatitis
Liver disease

Diverticulosis
Hernia
Hemorrhoids
Blood transfusion
Neuralgia or neuritis
Tension/anxiety
Depression
Childhood hyperactivity
Chicken pox
German measles
Drug abuse

Scarlet fever
Measles
Mumps
Polio
Rheumatic fever
Malaria
Osteoporosis
Mononucleosis
Sexually transmitted disease
Tuberculosis
Other: _____

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1. Aching muscles or joints
2. Swollen joints
3. Back or shoulder pains
4. Painful feet
5. Skin problems
6. Itching or burning skin
7. Bleed easily
8. Bruise easily
9. Faintness
10. Numbness
11. Convulsions
12. Change in handwriting
13. Tremble or shake
14. Difficulty in making decisions
15. Lack of concentration or memory
16. Lonely or depressed
17. Cry often
18. Hopeless outlook
19. Difficulty relaxing
20. Worry a lot
21. Frightening dreams or thoughts
22. Shy or sensitive
23. Loses temper
24. Annoyed by little things
25. Work or family problems
26. Sexual difficulties
27. Considered suicide
28. Desired psychiatric help
29. Weight changes
30. Tend to be hot or cold
31. Loss of interest in eating
32. Always hungry
33. More thirsty lately
34. Armpits or groin swelling
35. Fatigue
36. Sleeping difficulties
37. Exercises less than 3 times per week
38. Smoke. Packs/day: _____
39. Two or more alcoholic drinks per day
40. More than 4 cups of coffee/tea per day
41. Regular use of sleeping pills, marijuana, tranquilizers
42. Used heroin, cocaine, LSD, PCP, etc
43. Drive more than 25,000 miles per year
44. Visited a foreign country recently
45. Heartburn
46. Bloated stomach
47. Belching
48. Stomach pains
49. Nausea
50. Vomited blood
51. Difficulty swallowing
52. Constipation
53. Loose bowels
54. Black or bloody stools
55. Grey stools
56. Pain with bowel movement
57. Rectal bleeding
58. Frequently get up at night to urinate
59. Urinate more than five times a day
60. Wet pants or bed
61. Burning or pains with urination
62. Urine brown, black or bloody
63. Difficultly starting urine flow
64. Constant feeling that have to urinate

Men only

65. Urine stream very weak and slow
66. Prostate trouble
67. Burning or discharge from penis
68. Swelling or lump on testicles
69. Painful testicles

Women only

70. Date of last menstrual period: _____
71. Menopause or hysterectomy
72. Last menstrual period normal
73. Heavy bleeding with periods
74. Bleeding between periods
75. Bleeding after intercourse
76. Recent vaginal itching or discharge
77. Examine breast at least once a month
78. Noticed any lumps or pain in breasts
79. Complications with birth control
80. Month and year of last Pap test: _____
81. Number of children: _____
82. Frequent headaches
83. Neck pains
84. Neck lumps or swelling
85. Wear glasses
86. Blurry vision
87. Eyesight worsening
88. See double
89. See colored halo around lights
90. Eye pains or itching
91. Watering eyes
92. Eye trouble last two years
93. Hearing difficulties
94. Earaches
95. Running ears
96. Buzzing or noises in ears
97. Motion sickness
98. Dental problems
99. Swellings on gums or jaws
100. Sore or sensitive tongue
101. Taste changes
102. Congested nose
103. Runny nose
104. Sneezing spells
105. Head colds
106. Nose bleeds
107. Sore throat
108. Hoarse voice
109. Wheeze or gasp
110. Coughing spells
111. Cough up phlegm (thick spit)
112. Coughed up blood
113. Chest colds often
114. Excessive sweating or night sweats
115. High blood pressure
116. Racing heart
117. Chest pains
118. Dizzy spells
119. Shortness of breath
120. Shortness of breath at night
121. More pillows to breathe at night
122. Swollen ankles or feet
123. Leg cramps
124. Heart murmur

I have indicated all known health conditions and will provide updates
Signature: _____

Patient Injury Description

Name: _____ Date: _____
Date of Injury: _____ Time: _____
Location: _____

Please describe in your own words what happened during the accident or injury. Please include what you were doing at the time and which areas of your body were immediately impacted or injured.