

THERAPEUTIC GRACE

Confidential Client Health History

The information on this form will be used for the purpose of determining the safety of your treatment. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Date: _____ Date of Birth: _____
 Address: _____ City: _____ Postal Code: _____
 Home Phone: _____ Business Phone: _____ Cell Phone: _____
 Email Address: _____ Occupation: _____ Hobbies: _____
 Height: _____ Weight: _____ Number of Children: _____
 Family Doctor: _____ Address: _____ Phone: _____
 Date of Last Physical Examination: _____ General Health Status Today: _____
 Have you had Massage before Yes No What brings you in for Massage _____
 Referred by, _____

	Surgery	Injury
Type		
Date		
Current Symptoms		

Current Medication Name	Condition Treated

	Other Current Health Care	Other Previous Health Care
<i>Chiropractic</i>		
<i>Physiotherapy</i>		
<i>Psychotherapy</i>		
<i>Massage Therapy</i>		
<i>Accupuncture</i>		
<i>Regular Exercise</i>		
<i>Other:</i>		

Infections

	Current	Previous
<i>Herpes</i>		
<i>Hepatitis</i>		
<i>Plantar Warts</i>		
<i>TB</i>		
<i>HIV, AIDS</i>		
<i>Infectious Skin Conditions</i>		
<i>Other:</i>		

Skin

	Current	Previous
<i>Bruise Easily</i>		
<i>Skin Conditions</i>		
<i>Loss of Sensation</i>		
<i>Other:</i>		

Head and Neck

	Current	Previous
<i>Vision Problems</i>		
<i>Contact Lenses</i>		
<i>Earaches</i>		
<i>Hearing Loss</i>		
<i>Headaches</i>		
<i>Other:</i>		

Respiratory

	Current	Previous
<i>Chronic Cough</i>		
<i>Shortness of Breath</i>		
<i>Bronchitis</i>		
<i>Asthma</i>		
<i>Emphysema</i>		
<i>Other:</i>		
<i>Family History of a Respiratory Disorder:</i>		

Women

	Current	Previous
Menstrual Problems		
Painful Menses		
Cramps		
Caesarian Section		
Gynecological Surgery		
Pregnant		
Menopausal Problems		
Other:		

Describe your frequency to the following:

Smoking	
Alcohol	
Exercise	
Coffee or Tea	
Vitamins	
Eating Habits	

Cardiovascular:

	Current	Previous
High Blood Pressure		
Low Blood Pressure		
Poor Circulation		
Heart Disease		
Chronic Congestive Heart Failure		
Myocardial Infarction		
Pacemaker or similar device		
Phlebitis		
Stroke		
Varicose Veins		
Hemophilia		
Other:		
Family History of a Cardiovascular Disorder:		

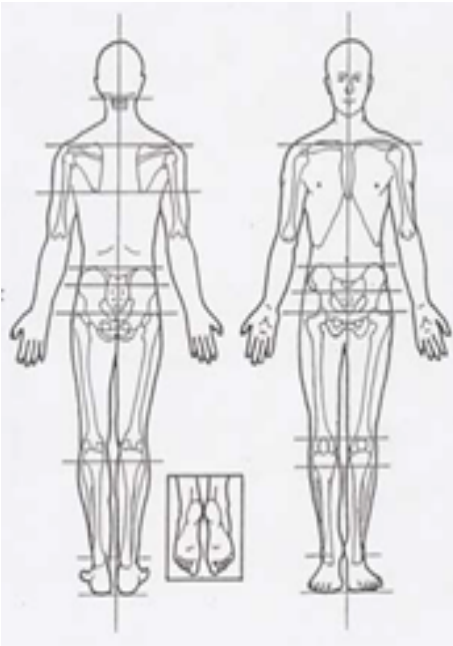
Miscellaneous (please add specifics)

	Current	Previous
Difficult Digestion		
Constipation		
Diabetes		
Liver		
Gallbladder		
Kidney		
Bladder		
Sinus		
Allergies		
Insomnia		
Cancer		
Arthritis		
Family History of an Arthritic Disorder:		
Epilepsy		
Other:		

Muscles

	Current	Previous
Neck		
Shoulders Left or Right		
Arm Left or Right		
Upper Back		
Mid-Back		
Low-Back		
Leg Left or Right		
Knee Left or Right		
Foot Left or Right		
Other:		

Notes:



Other Medical Conditions: _____

NOTE: (pins, wires, plates, artificial limbs or joints, special equipment such as wheelchair, walker, cane, crutches, etc.)

Signature: _____ **Date:** _____