PERSONAL HEALTH HISTORY

Date: _____ Name: _____
Address: _____
City _____ State: _____ Zip: _____
Phone (H): _____ (W): _____
Date of Birth : _____ Age: _____ Place raised: _____
Married ☐ Single ☐ Divorced ☐ Significant Other ☐ Widow ☐
Height: _____ Weight: _____ Desired Weight: _____
Allergies: _____
Occupation: _____ Employer: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Referred By: _____
Children: Name(s), Age(s), Living with you? _____
_____

Are you currently under a doctor's care? _____ For what? _____
Current practitioners:
Name: _____ Address: _____ Phone: _____
_____ _____ _____
Treatment Goals: (physical, emotional, etc.)
1. _____
2. _____
3. _____

Have you ever received reflexology or other bodywork sessions? _____
Specify: _____ How often? _____

Stressors in your life: (Rate stress level 1-10. Ten is the worst.)
Family: _____ Social: _____ Work Related: _____ Stress in your body? _____ Other? _____
Where do you hold your tension? _____

Exercise: (Y) (N) What? _____ How often? _____ How long? _____
Energy level and pattern? (least and most productive time of day)
_____

Pregnant? _____ Due date? _____

Serious past illnesses? _____
_____

Accidents, Injuries and dates? _____
_____

Hospitalizations and dates? _____
_____

Current prescription medications? _____
_____

Current herbs and supplements? _____
_____

SYMPTOM SURVEY

Check and fill in if applicable.

General:
- ☐ General Fatigue
- ☐ Loss of or excessive gain in weight
- ☐ Average hours of sleep per night _____
- ☐ Quality of sleep: Good Fair Poor
- ☐ Insomnia
- ☐ Motion sickness
- ☐ Sore or bleeding gums

Other _____

Respiratory:
- ☐ Sinus Problems
- ☐ Difficulty breathing deeply
- ☐ Nosebleeds
- ☐ Frequent coughing
- ☐ Frequent colds/sore throats

Other _____

Cardiovascular:
- ☐ Rapid or skipped beats
- ☐ Varicose veins
- ☐ Bruise easily
- ☐ Chest pain
- ☐ Cold hands/feet
- ☐ Shortness of breath with activity
- ☐ High blood pressure

Other _____

Neuromuscular:
- ☐ Headaches
- ☐ Muscle pain Where? _____
- ☐ Muscle cramping
- ☐ Weakness in arms or legs
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Frequent dislocations
- ☐ Jaw pain/tension (TMJ)
- ☐ Frequent bone fractures
- ☐ Memory loss
- ☐ Absent minded
- ☐ Numbness/tingling Where _____

Other _____

Skin:
- ☐ Skin eruptions
- ☐ Excessive sweating Where _____
- ☐ Dry or oily skin
- ☐ Hair loss

Other _____

Urinary:
- ☐ Frequent urination
- ☐ Involuntary escape of urine
- ☐ Burning/discharge on urination
- ☐ Weak urine stream
- ☐ Difficulty starting urine
- ☐ Constant urge to urinate
- ☐ Bedwetting
- ☐ Flank pain
- ☐ Number of times awaken in night to urinate _____
- ☐ Frequent urinary tract infections

Other _____

Senses:
- ☐ Glasses/contacts
- ☐ Eyesight worsening
- ☐ Hearing difficulties
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Dizzy/loss of balance

Other _____

Digestive:
- ☐ Frequent indigestion
- ☐ Heartburn
- ☐ Gas/bloating
- ☐ Nausea/vomiting
- ☐ Abdominal cramping
- ☐ Frequency of Bowel movements _____
- ☐ Alternating constipation/diarrhea
- ☐ Consistency of stools hard firm soft loose
- ☐ Pain/itching in rectum
- ☐ Hemorrhoids
- ☐ Excessive or loss of appetite

Other _____

Endocrine:
- ☐ Swollen glands
- ☐ Excessive thirst, hunger, sweating, urination
- ☐ Slow/fast metabolism
- ☐ Blood sugar imbalances
- ☐ Thyroid problem such as low energy

Other _____

Men:
- ☐ Burning/discharge on urination
- ☐ Lumps/swelling of testicles
- ☐ Pain in prostate or testicles
- ☐ Sores on penis or scrotum
- ☐ Hernia
- ☐ Impotence

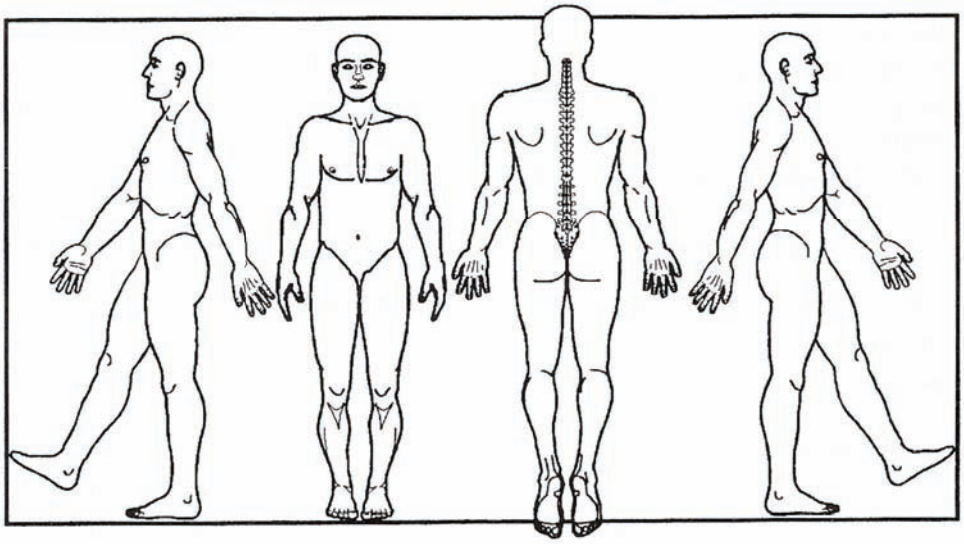
Other _____

Current Medical Concerns:

- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Blood Clots
- ☐ Headaches
- ☐ Asthma
- ☐ Diabetes
- ☐ Hemophilia
- ☐ Multiple Sclerosis
- ☐ HIV
- ☐ Heart Problems
- ☐ Breast Lumps
- ☐ Infections
- ☐ Liver Problems
- ☐ Epilepsy
- ☐ Stomach ulcers
- ☐ Cancer
- ☐ Lupus
- ☐ Chronic Fatigue

☐ Other
Specify:_____

_____
_____
_____
_____
_____
_____
_____
_____

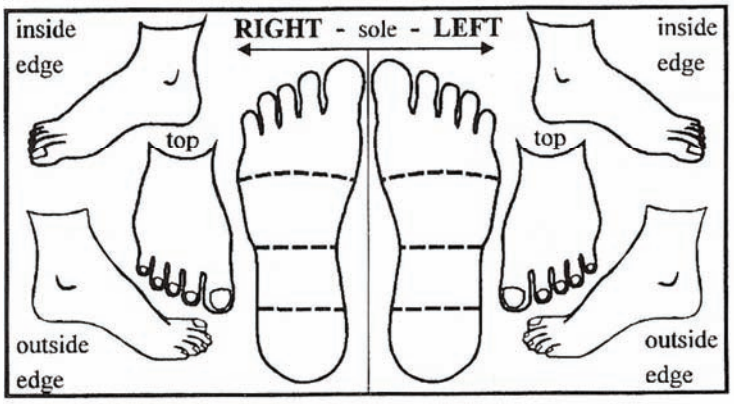


× Mark any area of concern:
(This can include pain)

Foot Problems?_____ Describe:_____

- ☐ Corns
- ☐ Puffiness
- ☐ Calluses
- ☐ Bunion
- ☐ Hammer toe
- ☐ Claw toe
- ☐ Warts
- ☐ Bone spur
- ☐ Pain
- ☐ Unusual color or rash
- ☐ Current injuries, bruises
- ☐ Ingrown toenail
- ☐ Scars, past injuries

× Mark areas of concern on foot chart.



☐ Other: _____

_____

Wellness Continuum

Please mark where you think you fall on this wellness continuum

Sick ——— **getting sick or better** ——— **ok** ——— **good** ——— **Your optimum health**

Addictions:

- ☐ Sugar
- ☐ Caffeine
- ☐ Salt

☐ Smoking
How many a day? _____
How long? _____

☐ Alcohol
How much? _____
How long? _____

☐ Drugs
Which ones? _____
_____

Women

Menses:

Do you have periods? ☐ Yes ☐ No

- ☐ Frequency and duration _____
- ☐ Amount of bleeding:
  scant, average, heavy, spotting
- ☐ Color: bright red, dark red, pink
- ☐ Clots? color _____
- ☐ Bleeding between periods

Other _____

PMS:

- ☐ Breast Lumps
- ☐ Sore breasts
- ☐ Irritable
- ☐ Depressed
- ☐ Emotional swings
- ☐ Bloating

Other _____

Menopause:

- ☐ Do you think you've started? ☐ Yes ☐ No
- ☐ Irregular cycles time frame _____
- ☐ Spotting
- ☐ Hot flashes
- ☐ Vaginal dryness/itching
- ☐ Depression

Other _____

Childbirth:

- ☐ Number of pregnancies _____
- ☐ Number of births _____
- ☐ Miscarriages ☐ Yes ☐ No
- ☐ Premature births
- ☐ Cesareans
- ☐ Abortions

Other _____

Infection:

- ☐ Vaginal pain/rash/irritation
- ☐ Vaginal discharge Color _____

Other _____

Other: _____

Cancellation Policy:

So that I may better serve my clients, 24 hrs. notice is required for cancellation. You will be charged for the full session with less than 24 hrs. notification.

Disclaimer

1. I understand that this work does not constitute nor is it a substitute for medical treatment, but rather is a form of health maintenance. I realize that this therapist is not a doctor and does not diagnose, prescribe or treat any specific condition.
2. I understand and agree that I am responsible for keeping my therapist informed of any changes in my physical condition, as this could effect the treatment I receive.

Signature: _____ Date: _____

(Do not write below this line.)

Notes: