Personal Pain History Form

Name: _____ **Date:** _____

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

PLEASE PRINT

What is your chief complaint at this time? _____

Where do you feel the pain/symptoms? _____

When did it start? _____
(include month and year and day if known)

How did it start? _____
(type of injury)

What makes the pain better? ☐ Ice ☐ Heat ☐ Rest ☐ Activity Other _____

How would you describe the pain? ☐ Dull ☐ Ache ☐ Burning ☐ Stabbing Other _____

At what time of the day and/or week is your pain worse? _____

Does the pain radiate to other areas of the body? If so, where? _____

On a scale of 0 to 10, (0 being no pain and 10 being worst pain) what would you rate your pain?

Now: ____/10 At Worst: ____/10 At Best: ____/10

Most of the time: ____/10 Morning: ____/10 Night: ____/10

Have you had this problem in the past? _____ If so, how often? _____

Does the pain/symptoms stop you from doing any task or movement? Is there a movement that makes the pain worse? (please describe)

_____

_____

Is your pain the result of a motor vehicle accident? _____

If so, have you filed with your insurance adjudicator? _____

Is your pain the result of a work related injury? _____

If so, have you filed a worker's compensation claim? _____

Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all the information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: (please print)_____ **Date of Birth:**_____
(first & last) (mm/dd/yr)

Occupation: _____ Have you received massage therapy before? ☐ Yes ☐ No

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No If yes, who? _____

If no, please indicate how you heard about the clinic. ☐ yellow pages ☐ flyer ☐ friend/family/coworker
☐ radio ☐ other: _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
☐ high blood pressure
☐ low blood pressure
☐ chronic congestive heart failure
☐ heart attack
☐ phlebitis/varicose veins
☐ stroke/CVA
☐ pacemaker or similar device
☐ heart disease

Respiratory
☐ chronic cough
☐ shortness of breath
☐ bronchitis
☐ asthma
☐ emphysema

Soft tissue/joint discomfort
☐ neck ☐ low back
☐ mid back ☐ upper back
☐ arms L/R ☐ legs L/R
☐ knees L/R ☐ shoulders L/R
Other_____

Infections
☐ hepatitis ☐ TB
☐ skin conditions ☐ HIV
☐ herpes

Other Conditions
☐ loss of sensation, where?
_____
☐ diabetes, onset: _____
☐ allergies/hypersensitivity to what?
_____
_____
☐ epilepsy
☐ cancer, where? _____
☐ skin conditions, what?
_____
☐ arthritis

Other Health Care:
☐ chiropractic ☐ naturopath
☐ physiotherapy ☐ osteopathy
☐ acupuncture ☐ reflexology
Other _____

Head/Neck
☐ history of headaches
☐ history of migraines
☐ vision problems/loss
☐ ear problems/hearing loss

Overall, how is your general health?
_____
Primary Care Physician:
_____
Do you currently get a sound 8 hours sleep per night?
_____
Do you feel alert every morning when you wake up?
_____

Women
☐ pregnant, due: _____
☐ gynecological conditions, what?
_____

Nutrition
Are you aware of how toxins are impacting your health? NO YES
Do you feel you get enough nutrition from the food you currently eat? NO YES
Do you experience regular stress? NO YES
Are you interested in learning more about nutritional cleansing and replenishing programs can protect and improve the quality of your health? NO YES

What is your primary complaint: _____

Current Medications: _____
_____
Condition it treats: _____

Surgery – date_____
nature:_____

Surgery – date_____
nature:_____

Injury – date_____
nature:_____

Injury – date_____
nature:_____

Do you have any internal pins, wire, artificial joints or special equipment? Yes ☐ No ☐
what?_____ where?_____

Do you have any other medical conditions? (eg. Digestive conditions, hemophilia, osteoporosis, mental illness)
Yes ☐ No ☐ Explain _____

NOTES (for therapists use)

Date of initial health history _____
Update 1_____ Update 2_____
Update 3 _____ Update 4_____