

# Tranquility In Motion

## Confidential Health History Form

Accurate Health History is required to receive therapy AND important to ensure that it is SAFE for you to receive a Massage as getting a massage affects the whole body/every system within the body. All information gathered for this treatment is confidential except as required or allowed by law. TRANQUILITY IN MOTION or the Owner Kylee Swetland will NEVER share your information with anyone without YOUR expressed approval. Birthdate is requested strictly for giving you a birthday present.

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Best Contact phone # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Last massage was how long ago? \_\_\_\_\_ Reason for Therapy \_\_\_\_\_

Occupation: \_\_\_\_\_ (are you at a desk all day, standing on concrete all day, etc)

If you were referred, please give a name so I can thank them \_\_\_\_\_

**Health History:** Please check space below for any condition that you are either currently experiencing or have experienced within the last 5 years. In the blank space, please identify where the problem is.

General Health Status (circle one)      EXCELLENT      GOOD      FAIR      POOR

### Soft Tissue/Joints

- Tendonitis/Bursitis \_\_\_\_\_
- Weakness \_\_\_\_\_
- Sprains / Strains \_\_\_\_\_
- Herniated Discs \_\_\_\_\_
- Arthritis (what kind and where?) \_\_\_\_\_

### Respiratory

- Chronic Cough
- Shortness of Breath
- Asthma
- Emphysema
- Pneumonia
- Sinus Problems

### Head Aches

- Tension Head aches (how often?) \_\_\_\_\_
- Migraines (how often) \_\_\_\_\_
- Tooth / Jaw / Ear Pain (circle)
- Head Trauma (when) \_\_\_\_\_

### Cardiovascular

- High Blood pressure (controlled with meds? \_\_\_\_\_)
- Low Blood Pressure (controlled with meds? \_\_\_\_\_)
- Heart Attack (when? \_\_\_\_\_)
- Stroke (when? \_\_\_\_\_)
- Pace Maker
- Congestive Heart Failure
- Any other heart disease?

### Accident / Injury

- Car accident (date) \_\_\_\_\_
- Whiplash
- Other Type of Accident

Date: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Physical Limitations: \_\_\_\_\_

- Bone Fractures \_\_\_\_\_

### Women

- Pregnant
- Is this your 1st pregnancy? \_\_\_\_\_

Due Date: \_\_\_\_\_

What trimester? \_\_\_\_\_

Any problems so far? \_\_\_\_\_

### Infectious Diseases

- Herpes  
Type: \_\_\_\_\_  
Active Flare up? \_\_\_\_\_
- Tuberculosis
- HIV
- AIDS
- Other: \_\_\_\_\_

Symptoms: \_\_\_\_\_

**Other Conditions**

Neurological Conditions  
What kind: \_\_\_\_\_  
Symptoms: \_\_\_\_\_

Epilepsy  
 Diabetes  
 Digestive Conditions  
What \_\_\_\_\_  
Symptoms: \_\_\_\_\_

Kidney or Bladder Issues  
 Fibromyalgia or Lupus (circle one)  
 Surgical Implants  
Where \_\_\_\_\_  
\_\_\_\_\_

Any other relevant conditions \_\_\_\_\_  
\_\_\_\_\_

**Skin**

Eczema  
 Bruise Easily  
 Varicose Veins  
 Athletes Foot  
 Any Warts (where \_\_\_\_\_)  
 Loss of sensation

**Allergies**

Essential Oils (what \_\_\_\_\_)  
 Seasonal  
 Other : \_\_\_\_\_

**Surgeries**

Date \_\_\_\_\_ Type \_\_\_\_\_

Current Issues related to surgery \_\_\_\_\_

Date \_\_\_\_\_ Type \_\_\_\_\_

Current Issues related to surgery \_\_\_\_\_

Date \_\_\_\_\_ Type \_\_\_\_\_

Current Issues related to surgery \_\_\_\_\_

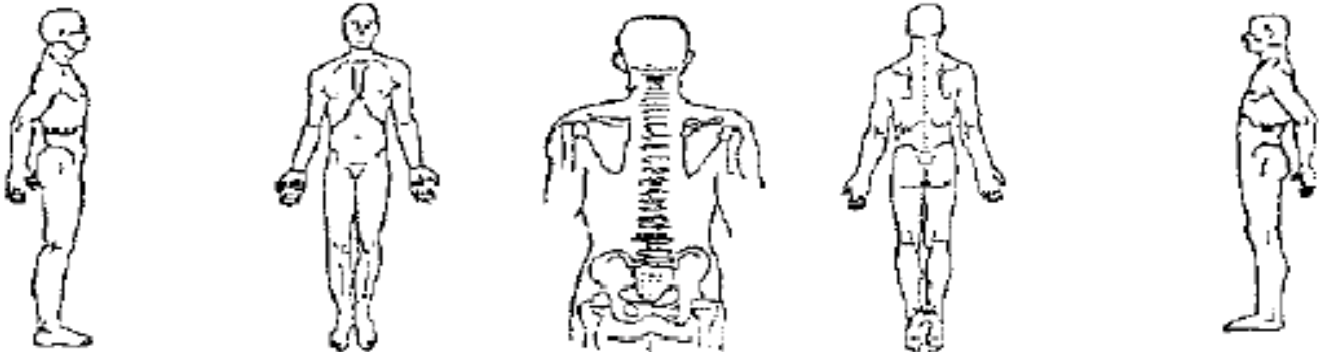
Date \_\_\_\_\_ Type \_\_\_\_\_

Current Issues related to surgery \_\_\_\_\_

**Current Medications : Please list the name if you can, or at least what it is taken for**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

**Please indicate problem area's (pain, stiffness, achiness) by shading in the area on the sketch below**



I (the client) understand that in order to minimize health risks, I have provided all my known medical information and I will inform the therapist of any new health issues and/or medications I acquire. I have read and understand the Client Policies. It is my choice to receive massage/bodywork therapy, and I give my consent to receive treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_