Tranquility In Motion

Confidential Health History Form

Accurate Health History is required to recieve 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?)

_____

Head Aches

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

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? _____

_____

Respiratory

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

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?

_____

Symptoms: _____

Infectious Diseases

- ☐ Herpes

Type:_____

Active Flare up?_____

- ☐ Tuberculosis
- ☐ HIV
- ☐ AIDS
- ☐ Other: _____

_____

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 _____

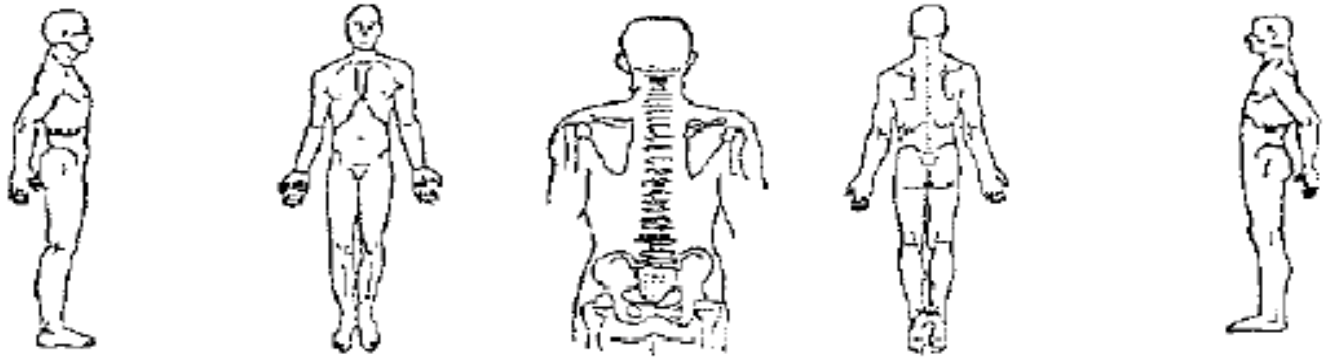
Date _____ Type _____
Current Issues related to surgery _____

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**_____