Archway To Renewal
natural therapies

CONFIDENTIAL HEALTH HISTORY

An accurate health history is important to ensure that it is safe for you to receive treatment. All information gathered for this treatment is confidential except to facilitate the assessment or treatment. You will be asked to provide written authorization for release of any information.

Date:_____

First Name: _____ Last Name:_____ Birthdate:_____

Address:_____ City:_____

Postal Code:_____Home Phone:_____ Business:_____

Cell Phone: _____ Email Address: _____

EMERGENCY CONTACT: _____Contact Number: _____

How Did You Hear About Us? _____

WHAT IS YOUR PRIMARY COMPLAINT? _____

HEALTH HISTORY:

(Please indicate conditions you are experiencing currently as **C** and previous as **P**)

Respiratory:
___Chronic cough
___Shortness of breath
___Bronchitis/Asthma
___Sinus infections
___Chronic cough/___smoking
___Emphysema
___Other:_____

Cardiovascular:
___Cold hands / feet
___Arm pain/weak/tingling
___Heart attack
___Varicose veins/phlebitis
___Poor healing of wounds
___Stroke/ CVA
___Pacemaker or other device
___Swelling in hands / feet
__ High/ low blood pressure
___Dizziness/ lightheaded

Other Conditions:
___Loss of sensation
___Diabetes (onset/type:____)
___Hypoglycemia
___Allergies
___Epilepsy
___Insomnia
___Depression /Anxiety
___Multiple Sclerosis
___Cancer (onset / type:____)
___Other:_____

Head and Neck:
___Tension/migraine headaches
___Tinnitus (ringing in ears)
___Tooth/ Jaw/ Ear pain
___Vision problems / loss
___Ear problems/hearing loss

Soft tissue / Joint / Nerve
___Fibromyalgia
___Arthritis__RA__OA
___Herniated/ Deg. disc(s) level
___Osteoporosis
___Fracture (where___)
___Thoracic Outlet Syndrome
___ Head trauma / concussion
___ Whiplash / car accident
___ Neck pain/stiffness/ injury
___ Shoulderpain/stiffness/injury
___ Carpal Tunnel syndrome
___Back pain/stiffness/ injury
___Leg pain/weakness/injury
___Knee or foot pain/ injury
___Tendonitis / tenosynovitis
___Bursitis or dislocations
___Sports / work injury

Skin:

___Bruise easily
___Rash/ open sores/ warts
___Sensitivity / allergies
___Contagious skin disease

Digestive:

___Constipation / diarrhea
___Nausea / vomiting
___Ulcers/ blood in stool
___Liver / kidney problems
___Quick weight gain/ loss
___Ulcerative colitis/crohn's/IBS

Infections:

___Hepatitis
___Tuberculosis
___HIV
___Painful Urination
___Flank pain

Women:

___Pregnant (due:_____)
___Painful menstruation
___Hysterectomy
___Birth Control

Other Questions: Y/N

___I get a good night sleep
___I eat a well balanced diet
___I have low energy
___I feel good about life

ADDITIONAL INFORMATION:

_____

Current Medications:

_____condition it treats: _____ Family Physician:_____
_____condition it treats:_____ Phone #:_____
_____condition it treats:_____Other Health Care Provider?
_____condition it treats:_____ _If yes, please specify:_____

Surgeries:

_____ date:_____ details:_____
_____ date:_____ details:_____

What sports activities do you participate in on a regular or seasonal basis?

I have read and completed this form and stated all medical conditions that apply to me to the best of my knowledge. I will notify the Massage Therapist of any changes in my health status to ensure my safety for receiving massage. I understand that Massage Therapists do not diagnose illness, disease, or any physical/mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform chiropractic adjustments. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a Medical Doctor for that service. I am aware that I may experience possible side effects 24-48 hours after treatment, such as temporary muscle discomfort. Icing is recommended.

ACUPUNCTURE TREATMENT (Please read and sign if applicable)

I understand and informed that in the practice of Acupuncture there are risks to treatment. These include but are not limited to minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, possible perforation of organs (extremely rare) and stuck or bent needles. I have been advised that only pre-sterilized single use needles will be used.

SIGNATURE: _____ DATE: _____

HEALTH HISTORY UPDATES: (6 MONTH INTERVALS)

HEALTH HX DATES
INITIAL
2ND
3RD
4TH
5TH
6TH
7TH
8TH
9TH
10TH
11TH
12TH