MOUNTAIN VIEW MANUAL THERAPY

Personal Health History Information

All information herein is strictly confidential.

Name _____ Birthday _____
Address _____ Phone (day) _____
City/State/Zip _____ Phone (eve) _____
Email _____ Referred by _____
Occupation _____
Doctor/Clinic _____ Chiropractor _____
Permission to consult with doctor/clinic? **Please initial:** Yes ____ No _____
Permission to consult with chiropractor? **Please initial:** Yes ____ No _____

Treatment Information

What is the reason for your visit? Please list any current symptoms.

_____
_____
_____

Are you currently seeing a medical professional? Yes ____ No _____
If yes, for what reason?

_____
_____

Have you ever suffered an injury/car accident? Yes _____ No _____

_____
_____
_____
_____
_____

Have you ever had surgery? Yes _____ No _____
If yes, please describe all injuries and include dates, diagnosis, and treament received.

_____
_____
_____

Are you pregnant? *Due date:* Yes _____ No _____
Do you have diabetes? Yes _____ No _____
Do you have vericose veins? Yes _____ No _____
Have you ever been diagnosed with blood clots? Yes _____ No _____
Have you ever been diagnosed with arthritis? Yes _____ No _____
Do you have any heart/blood pressure problems? Yes _____ No _____
Do you have any digestive problems? Yes _____ No _____

Please describe in further detail any condition answered "yes" above:

_____
_____
_____

Personal Health History Information

All information herein is strictly confidential.

Current symptoms:			**often**	**occasional**	**duration of symptom**
Y	N	headaches	_____	_____	_____
Y	N	neck pain/stiffness	_____	_____	_____
Y	N	shoulder pain/restriction	_____	_____	_____
Y	N	pain between shoulders	_____	_____	_____
Y	N	back pain	_____	_____	_____
Y	N	general muscle stiffness/ soreness	_____	_____	_____
Y	N	numbness/tingling in arm/ hand	_____	_____	_____
Y	N	sore, stiff/aching hips	_____	_____	_____
Y	N	nerve pain down legs	_____	_____	_____
Y	N	restricted motion in any area	_____	_____	_____
Y	N	foot problems	_____	_____	_____
Y	N	pain when performing certain motions	_____	_____	_____
Y	N	other - please describe	_____	_____	_____

Please use this space if you wish to further explain your symptoms.

_____

_____

_____

Current medications:

_____

_____

_____

Exercise: Activity Frequency

_____

_____

List any other medical or physical condition that has not been mentioned on this form.
(Please include dates, medications, and treatment received.)

_____

_____

_____

The massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals. Massage therapy is not a substitute for medical examinations and/or diagnosis. Because the massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. I consent to receive treatment by the massage therapist.

Signature _____ *Date* _____