TouchStone Health - Health History Form

Name ____ M F

Address __________________________ City ________________________

Postal Code _______________________ Birth Date _____________________

Home Phone _________________ Work Phone ________________________

Occupation ____

Medical Doctor _______________ Doctor's Phone & Address ________________

How did you hear about TouchStone Health? ______________________________

Do you have any medical conditions not listed on the next page? Y N
If yes, please describe ____

Do you have any internal wires, artificial joints, pacemakers/special equipment that I should be aware of? Y N If yes, please describe __________________________________

Please circle areas which are currently causing you symptoms of pain, stiffness, numbness or other forms of discomfort:

Face Upper back Arm(s) Hand(s) Thigh(s) Ankle(s) Neck
Low Back Elbow(s) Finger(s) Knee(s) Feet Shoulder(s)
Wrist(s) Hips(s) Leg(s) Toe(s) Chest Ribs

What condition or reason are you seeking treatment for today?____________________
____

Have you or are you seeing any other health care professional(s) for this condition? Y N
If yes, please describe who ____

Have you ever been involved in any motor vehicle accidents Y N Date:_____
Have you been involved in any other accidents? Y N Date:_____

Briefly list any surgeries you have undergone, for what and when: ____________________
____

Are you presently taking any prescribed medication(s) Y N
If yes, please list the medication(s) and the condition(s) for which it is being used for if known.
____
____

Have you ever received massage therapy treatment before? Y N

How would you describe your current health? ____________________________________

Blood Pressure
Date_________________ Date_________________ Date_________________

Cardiovascular
- High blood pressure
- Low blood pressure
- Chronic congestive heart failure
- Heart Attack
- Phlebitis/Varicose Veins
- Stroke/CVA
- Pacemaker or device
- Heart disease
- Dizziness/vertigo
- Seizures

Is there a family history of any of the above?

Y N

Respiratory
- Asthma
- Bronchitis
- Emphysema
- Chronic Cough
- Shortness of Breath

Is there a family history of any of the above?

Y N

Digestive
- Constipation
- Crohns Disease
- Colitis
- Irritable Bowel Syndrome
- Ulcers

Head and Neck
- History of Headaches
- History of Migraines
- Vision Problems
- Vision Loss
- Ear Problems
- Hearing Loss

Muscle/Joint
- Neck
- Back (lower)
- Back (mid)
- Back (upper)
- Shoulders
- Elbow
- Wrist/Hand
- Hip
- Knee
- Ankle/Foot
- Spine

Other
- Loss of sensation

Where?________________
- Diabetes

Onset __________________

Type ___________________
- Allergies/Hypersensitivity

To what?________________
- Epilepsy
- Cancer

Type/Location ___________
- Arthritis

Is there a family history of arthritis?

Y N
- Hemophilia
- Fibromyalgia
- Chronic Fatigue
- Scoliosis
- Polio/Post Polio
- Osteoporosis

Women
- Pregnancy

Due Date_________________
- Previous pregnancy

complications________________

____
- Menopausal Problems

____
- Menstrual problems

____
- Gynecological conditions

Describe ____________________