

Integrated Center for Optimum Health, LLC.

Confidential Health Information Form

Please answer the following questions by checking the appropriate box and providing any necessary clarifications

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a professional massage? What other ways do you relieve stress?
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly or participate in any sports? Which ones and how often?
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently under the care of a physician or other health care provider for a specific condition? Please describe.
<input type="checkbox"/>	<input type="checkbox"/>	Do you have skin problems or allergies? Please describe.
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had surgery? Please describe
<input type="checkbox"/>	<input type="checkbox"/>	Do you have or have you ever had cancer? Please describe.....
<input type="checkbox"/>	<input type="checkbox"/>	Do you have or have you ever had heart problems? Please describe
<input type="checkbox"/>	<input type="checkbox"/>	Do you have high or low blood pressure? Please describe.....
<input type="checkbox"/>	<input type="checkbox"/>	Do you have varicose veins, blood clots, or any other circulatory problems? Please describe.....
<input type="checkbox"/>	<input type="checkbox"/>	Do you have diabetes? How is it controlled?.....
<input type="checkbox"/>	<input type="checkbox"/>	Do you have arthritis? Circle which type: OSTEOARTHRITIS or RHEUMATOID arthritis. Where is it located?.....
<input type="checkbox"/>	<input type="checkbox"/>	Do you have spinal problems? Please describe.....
<input type="checkbox"/>	<input type="checkbox"/>	Do you experience prolonged episodes of depression or other emotions?.....
<input type="checkbox"/>	<input type="checkbox"/>	Do you have an infectious or contagious diseases? Please describe.....
<input type="checkbox"/>	<input type="checkbox"/>	Are you experiencing any sleep disorders at this time?.....
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? What stage are you at?.....
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses? Are they HARD or SOFT lenses?
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures?
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear hearing aids?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any needs that require special attention? Please specify
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other medical condition that I should be aware of before you receive a massage? Please describe.....
<input type="checkbox"/>	<input type="checkbox"/>	Do you want specific results from your massage? Please describe
		Use the space below for additional comments:.....

I understand that massage practitioners do not diagnose illness, disease, or other physical or mental disorders. Massage practitioners do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitution for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. I have stated all my known medical conditions and take it upon myself to keep the massage practitioner updated on my physical health.

Signature: _____ Date: _____

Name: _____ Date: _____

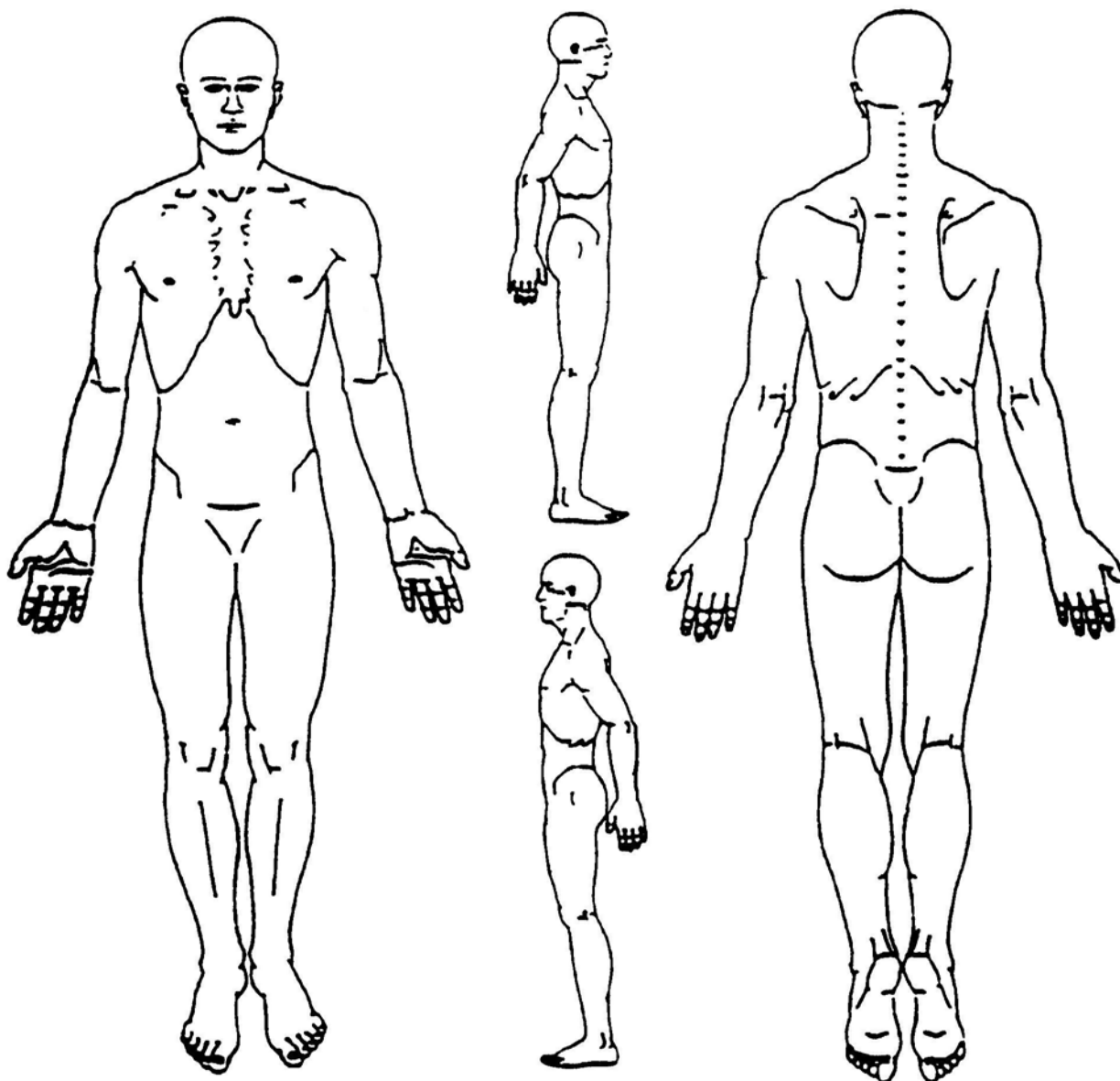
Previous History (injuries, falls, surgeries)

Date

Treatment

Symptoms or Problem Areas: Rate the intensity of symptoms as *mild*, *moderate*, or *severe* and length of time they have occurred.

On the figures below: mark the location of symptoms and label injuries, both previous and current.



Integrated Center for Optimum Health, LLC

(Confidential)



Patient's Name: _____

Today's date: _____

Please answer all questions in reference to your current status.

Are you currently working?

<input type="checkbox"/>	<i>Yes</i>	<input type="checkbox"/>	<i>No</i>
<input type="checkbox"/>	<i>Part-time</i>	<input type="checkbox"/>	<i>Full-time</i>
<input type="checkbox"/>	<i>Light duty</i>	<input type="checkbox"/>	Regular duty

Are you able to continue your recreational and sports activities?

<input type="checkbox"/>	<i>Yes</i>	<input type="checkbox"/>	<i>No</i>
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	I cannot!	Less than 5 minutes	Less than 15 minutes	Less than 45 minutes	Between 1-2 hours	More than 2 hours
How long can you sit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How long can you stand?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How long can you walk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How long can you drive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	I cannot!	Less than 5 lbs.	Less than 15 lbs.	Less than 25 lbs.	Between 25-60 lbs.	More than 60 lbs.
How much can you lift?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much can you carry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please mark the most appropriate answer to your current status:

	<i>No</i>	<i>1x</i>	<i>2-10x</i>	<i>11-25x</i>	<i>> 25x</i>
Can you squat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you kneel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you bend/stoop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<i>Yes</i>	<i>No</i>			
Can you climb stairs/hills?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you awaken at night?	<input type="checkbox"/>	<input type="checkbox"/>			
Can you reach overhead?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> daily	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly
Do you have difficulties reading?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you need medication for pain relief?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> daily	<input type="checkbox"/> weekly	
Are you performing exercises?	<input type="checkbox"/>	<input type="checkbox"/>			

What treatment other than massage therapy do you receive?

List all your current medications:

Current Pain Scale Rating (circle) 0 1 2 3 4 5 6 7 8 9 10

Maximum Functional Capacity Rating 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Please describe all other limitations: