

Client Health History Form

Please fill out completely, sign, and bring with you to your first appointment.

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Daytime phone _____ Evening phone _____

Cell phone _____ E-mail address _____

Occupation _____ Birth date _____ Male Female

► How did you hear about me? Osteopathic Center for Healing/Neil Spiegel, D.O.
 PMTI AMTA ABMP Website/Internet Friend Other _____

► Have you ever had a professional massage before? Yes No

CURRENT HEALTH

► Where are you currently feeling pain or tension?

► Do you have limited range of motion? No Yes Where?

► What exercise do you regularly perform?

► Do you have allergies or sensitivity to: oils lotions scents

► Are you pregnant? No Yes If yes, what week?

► Are you currently under a doctor or therapist's care? No Yes If yes, for what?

► Are you taking any medication (including over the counter meds)?

Blood pressure meds Blood thinners Pain killers Cortisone injections
 Anti-inflammatories Muscle relaxants Anti-depressants Other _____

MEDICAL HISTORY

► Please describe any past injuries or surgeries:

► Please check any of the following conditions you have now or have had in the past:

Allergies Jaw pain or TMJ High/low blood pressure Loss of balance Headaches/Migraines
 Asthma Skin disorders Rheumatoid arthritis Fibromyalgia Thyroid Disorders
 Diabetes Ringing in ears Broken/fractured bones Pinched nerves Heart disease/attack
 Fatigue Blood clots Numbness/pins/needles Edema (swelling) Varicose veins
 Sciatica Osteoarthritis Osteoporosis/osteopenia Anemia, bruise easily Dizziness
 Slipped/degenerative/fused disc(s) Scoliosis Tendon/ligament/cartilage/muscle tear(s)

Cancer: specify primary site _____

Lymph node removal: specify location _____

Other, please specify _____

