Health History Form

Name:_____

Phones: evening_____other_____

Address:_____Age:_____Birthdate:_____

City/State/Zip:_____Email: _____

The following form is thorough because all components of your health can affect the health of your tissues and structure. Additionally, having a detailed and comprehensive understanding of your health allows us to help our clients figure out what other activities, behaviors, or choices you can explore outside of our sessions to support your health.

This form must be completed before your initial visit. Please fill out the form and email it to bodydynamicsrolfing@gmail.com.

Please check the musculoskeletal conditions that you currently experience or have experienced in the past:

Current	Past	Connective Tissue / Bone / Muscle Conditions	
☐	☐	Arthritis	which joint(s) _____
☐	☐	Bulging/herniated disc	which vertebra(e) _____
☐	☐	Bursitis	which joint(s) _____
☐	☐	Fibromyalgia	diagnosed at what age _____
☐	☐	Hernia	hiatal ☐ abdominal ☐ inguinal ☐
☐	☐	Joint stiffness/swelling	which joints _____
☐	☐	Muscle spasms/cramps	which muscles _____
☐	☐	Osteoporosis	diagnosed at what age _____
☐	☐	Sciatica	right ☐ left ☐
☐	☐	Scoliosis	diagnosed at what age _____
☐	☐	Tendonitis	which joints _____

Current	Past	Pains of Joints and Areas	Location		Suspected cause of pain (i.e., injury, work setup, repetitive activities, etc.)
☐	☐	Chronic headaches/ migraines	area(s) of regular pain _____		_____
☐	☐	Jaw pain/TMJ	right ☐	left ☐	_____
☐	☐	Neck pain	right ☐	left ☐	_____
☐	☐	Upper back	right ☐	left ☐	_____
☐	☐	Shoulder pain	right ☐	left ☐	_____
☐	☐	Elbow pain	right ☐	left ☐	_____
☐	☐	Wrist/hand pain	right ☐	left ☐	_____
☐	☐	Chest/ribs/abdominal pain	right ☐	left ☐	_____
☐	☐	Lower back	right ☐	left ☐	_____
☐	☐	Hip pain	right ☐	left ☐	_____
☐	☐	Leg pain	right ☐	left ☐	_____
☐	☐	Knee pain	right ☐	left ☐	_____
☐	☐	Ankle/foot pain	right ☐	left ☐	_____

Please check the health conditions that you currently experience or have experienced:

Current	Past	Energy / Mood / Nervous System
☐	☐	Anxiety
☐	☐	Brain fog/difficulty concentrating
☐	☐	Chronic fatigue syndrome
☐	☐	Depression
☐	☐	Dizziness/fainting/balance issues
☐	☐	Epilepsy
☐	☐	Fatigue
☐	☐	Sleep problems
	☐ insomnia ☐ can't stay asleep ☐ other	
☐	☐	Thyroid disease

Current	Past	Digestion
☐	☐	Constipation
		☐ chronic ☐ occasional
☐	☐	Diarrhea
		☐ chronic ☐ occasional
☐	☐	Food allergies
☐	☐	Food cravings
		what foods _____
☐	☐	Regular stomachaches
☐	☐	Ulcers
☐	☐	Other digestive issues

Current	Past	Kidneys / Lymph
☐	☐	Bladder/kidney infections
		year of last infection _____
☐	☐	Kidney disease
☐	☐	Edema/fluid retention
		what area of the body _____
☐	☐	Chronic swollen lymph nodes

Current	Past	Illnesses
☐	☐	Cancer/tumor
		kind _____ year _____
☐	☐	Diabetes
☐	☐	Ear infections
☐	☐	Hepatitis
☐	☐	Rheumatic fever
☐	☐	Shingles
☐	☐	Sinus infections

Current	Past	Respiration
☐	☐	Asthma/respiratory problems
☐	☐	Inhalant allergies/hay fever

Current	Past	Heart / Blood
☐	☐	Anemia
☐	☐	Bleeding/clotting disorder
☐	☐	Chronic cold hands or feet
☐	☐	Chronic venous insufficiency
☐	☐	Easy bruising
☐	☐	Heart attack
		what year _____
☐	☐	High blood pressure
☐	☐	Phlebitis/blood clots/varicose veins
☐	☐	Stroke
		what year _____
☐	☐	Other heart condition

Current	Past	Skin
☐	☐	Athlete's foot
☐	☐	Brittle nails
☐	☐	Dry skin/itchiness
☐	☐	Eczema
☐	☐	Hives
☐	☐	Psoriasis
☐	☐	Scleroderma

Current	Past	Reproductive
☐	☐	Endometriosis
☐	☐	Infertility
☐	☐	Hysterectomy
		☐ partial ☐ full
☐	☐	Low libido
☐	☐	Peri-/menopausal symptoms
		what symptoms _____
☐	☐	PMS symptoms
☐	☐	Pregnancy
		# of pregnancies____# of live births _____
		☐ vaginal delivery ☐ Caesarean
☐	☐	Other reproductive issues

Additional Reproductive Questions for Women:
Average length of your cycle_____days
Average length of menstruation_____days
Are you trying to conceive? yes ☐ no ☐
Do you have an IUD? yes ☐ no ☐

Any additional symptoms or illnesses not mentioned above: _____

Traumas - injuries, accidents, and surgeries (please include approximate year or age of trauma):

_____ abdominal surgery,_____appendectomy,_____bike accident,_____birth trauma,_____broken or dislocated bones_____car accident,_____concussion,_____falls,_____joint replacement surgery, _____ labor/delivery trauma,_____pulled or torn muscles,_____root canals or other major dental work, _____ sprains,_____tonsillectomy,_____verbal/physical/sexual abuse,_____other surgeries or accidents

Additional details about these traumas: _____

_____

Medications and Supplements

Medications	For what condition	Haven taken for how long

Supplements (vitamins, minerals, etc.) _____

_____

Diet

Do you consume the following:	Every day	Most days	Occasionally	Never, I avoid this?
Sugar	☐	☐	☐	☐
Dairy	☐	☐	☐	☐
Wheat	☐	☐	☐	☐
Soy	☐	☐	☐	☐
Peanuts	☐	☐	☐	☐
Meat	☐	☐	☐	☐
Premade meals (e.g., frozen dinners, boxed dinners, canned soups)	☐	☐	☐	☐
Condiments (e.g., ketchup, soy sauce, salad dressing, mayo)	☐	☐	☐	☐
Fried foods (e.g., chips, crackers french fries, doughnuts)	☐	☐	☐	☐
Restaurant meals	☐	☐	☐	☐
Fast food	☐	☐	☐	☐

Any other foods you avoid, such as salt or other allergens: _____

Do you follow a particular diet (i.e., gluten-free, vegan, Paleo Diet, etc.)? _____

	Yes	No	If yes, how many / how often
Caffeinated coffee, tea, or soda	☐	☐	_____ cups or cans / day, week, month
Diet soda	☐	☐	_____ cups or cans / day, week, month
Alcohol	☐	☐	_____ drinks / day, week, month
Cigarettes	☐	☐	_____ cigarettes / day, week, month

If yes, for how many years? _____

How much water do you drink daily? _____

Physical Habits

Are you right-handed ☐ or left-handed ☐?

How do you sleep? On your: side ☐ back ☐ stomach ☐ On average, I sleep_____hours per night.

Do you wear glasses or contacts? Yes ☐ No ☐

Do you sit on your wallet regularly? Yes ☐ No ☐

Do you wear shoes with elevated heels: 1-7 times a week ☐ 1-4 times a month ☐ rarely/never ☐?

How would you rate your general energy? Very good Good Fair Poor Very poor

On a scale of 1 to 10 (1 = lowest), what is the amount of stress/tension in your life? 1 2 3 4 5 6 7 8 9 10

Do you exercise regularly? Yes ☐ No ☐

If so, what type of exercise and how often?_____

Occupation_____

Have you received a massage or bodywork before? Yes ☐ No ☐ If so, how recently?_____

Reason for today's visit: _____

What is going well in your life? _____

_____

Primary care physician _____ Other health care provider _____

(e.g., medical specialist, chiropractor, acupuncturist)

In case of an emergency, contact: Name_____Telephone_____

If you were referred to our office, who referred you? _____

The information above is complete and accurate to the best of my knowledge. I understand that bodywork therapy does not take the place of physicians' services. The work and information that I receive during a session is for the purposes of improving my general health. I will keep the therapist informed of any changes in my health as they occur.

My signature below indicates that I understand and agree to the above conditions.

Signature_____Date _____

Additional information:

- The benefits of bodywork can be more readily received when you are comfortable, so please let us know if elements of your session are not comfortable for you.
- For Rolfing® sessions, clients usually wear underclothing.
- All details of a client's session are private and confidential.
- If you must miss a scheduled appointment, we ask that you cancel your appointment 24 hours in advance.
- Sessions that begin late due to the client's having arrived late end at the appointed time and are full price.
- Payment is expected at the time service is rendered. We accept cash, checks, and credit cards.
- This is a scent-free office. Please refrain from wearing perfume or cologne to your appointment.