BERNADETTEMORIN
registered massage therapist

Please tell me about yourself

Name: _____

Name you prefer to be called?: _____ Date of Birth: Day _____ Month_____ Year_____

Address:_____ Postal Code: _____

Phone: Home: _____ Mobile: _____ Work: _____

E-mail: _____ Occupation: _____

Marital Status: Single Married Divorced Widowed Other Children: No Yes, #_____

Doctor Name & Address: _____ Phone: _____

Have you ever had Massage/Acupuncture before? No Yes When last seen: _____

Do you see a Chiropractor/Osteopath? No Yes When last seen: _____

How did you hear about me? _____

Health History

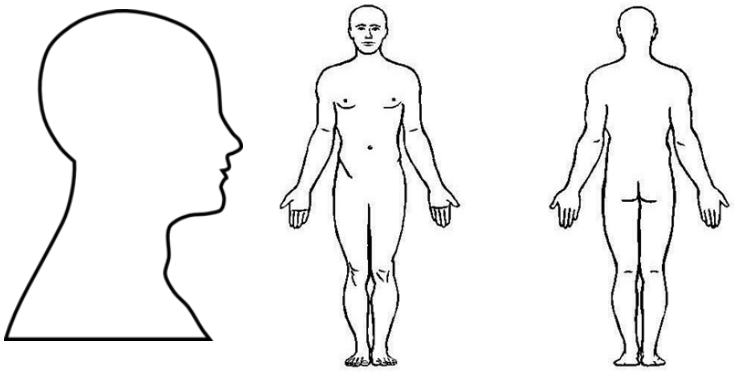
1. What brings you here today? Wellness or Complaint

2. If a complaint, please list in order of severity:

i) _____

ii) _____

iii) _____



3. Please SHADE in the affected area(s) and CIRCLE symptoms that apply:

Achy Stiffness Weakness Numbness Sharp
Cramping Burning Pins & Needles

4. List other professionals/doctors you have consulted for these conditions:

i) _____ When: _____

ii) _____ When: _____

iii) _____ When: _____

Did their treatment help? Explain:

_____

_____

Were X-rays, MRI or CT scans performed? No Yes When: _____

5. How does this complaint affect your life? What are you unable to do?

_____

_____

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So that I may provide you with the best care, please inform me if you have ever tested HIV positive or have been diagnosed with cancer. This information will be held in the strictest confidence.

General symptoms
Headaches
Dizziness
Clumsiness
Fainting
Blackouts
Loss of consciousness
Convulsions
Sweats
Fever
Nervousness
Loss of weight
Numbness or tingling pain

Muscles and Joints
Stiff neck
Backache
Swollen joints
Painful tailbone
Foot trouble
Shoulder pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Arthritis
Weakness or loss of strength

Eye, Ear, Nose & Throat
Blurred vision
Failing vision (one/both eyes)
Crossed eyes
Double vision
Eye pain
Deafness
Earache
Tubes in ears, when _____
Ringing or buzzing in ear
Frequent colds
Sinus infection
Enlarged glands
Enlarged thyroid
Difficulty swallowing
Speech impediment
Headaches
Migraines

Respiratory
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficult breathing/Shortness of breath
Asthma
Bronchitis
Emphysema

Cardiovascular
Bleeding disorder
Blood pressure High/Low (circle)
Pain over the heart
Stroke/CVA
Hardening of the arteries
Varicose veins/Phlebitis
Swelling of the ankles
Poor circulation
Heart or blood disease
Angina
Heart Attack
Pacemaker

G.U. for Women
Painful menstruation
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Vaginal discharge
Swollen breasts
Lumps in breasts
Menopause Peri/Mid/Post

Now Pregnant Y/N
due date_____

# of pregnancies
miscarriages
therapeutic abortions

deliveries
vaginal
c-section

Skin
Rashes, itching
Bruise easily
Dryness
Boils
Hives (allergy)
roseacea, eczema, psoriasis

Gastrointestinal
Poor appetite
Indigestion
Excessive hunger
Belching or gas
Nausea
Vomiting (blood?)
Pain over stomach
Constipation
Diarrhea
Hemorrhoids (piles)
Jaundice
Gall bladder trouble
Intestinal worms
Ulcer

Genitourinary
Trouble urinating
Blood in urine
Kidney infection
Bed wetting
Prostate trouble

Braces worn Y/N what age ___
How long worn for _____
Retainer Y/N is it permanent Y/N
On upper or lower teeth
Night Guard Y/N

Have you ever had any fractures (broken bones)? O yes O no
Which:

Internal pins/wires, artificial joints or special equipment Y/N
What & where:

Other traumas

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6. Are you currently taking any Medications/Supplements or Vitamins? No Yes, please list:

_____
_____

7. Please list any OPERATIONS, ACCIDENTS, and/or HOSPITALIZATIONS and when they occurred:

_____
_____
_____
_____
_____

8. Have you had and/or is there a family history of:

Cancer	Arthritis	Heart Disease	Diabetes
Depression/mental Illness	Osteoporosis	Epilepsy	Fibromyalgia

9. Do you smoke? No Yes, how much per day?

Lifestyle

10. What are your hobbies/leisure time pursuits? _____

11. How many hours do you work per week on average? _____

12. What activities does your job typically involve? _____

13. In what position do you sleep most commonly? _____

14. How many hours of sleep do you get on an average night? Is it restful? _____

15. How much do you drink per day? Tea: Coffee: Pop: Alcohol: Water:

16. How would you rate your overall level of HEALTH? Mark a vertical line below:

VERY SICK ----------VERY HEALTHY

17. List things that you do to promote good health:

_____
_____
_____

18. What health GOALS are you hoping to achieve as a result of your care here?

_____
_____
_____

19. What is your level of COMMITMENT to achieving these goals? Mark a vertical line below.

VERY LOW----------VERY HIGH