

## Health History Information

Surgeries \_\_\_\_\_

Major illnesses/ hospitalizations \_\_\_\_\_

Injuries or accidents still affecting you \_\_\_\_\_

Please mark any of the following conditions you are currently dealing with, or have dealt with in the past. Mark with a **C** for Current, or **P** for Past. Please use the space next to each item for details when applicable. Leave blank if it doesn't apply to you.

\_\_\_ tendonitis \_\_\_\_\_

\_\_\_ bursitis \_\_\_\_\_

\_\_\_ arthritis \_\_\_\_\_

\_\_\_ broken bones \_\_\_\_\_

\_\_\_ osteoporosis \_\_\_\_\_

\_\_\_ sprains/strains \_\_\_\_\_

\_\_\_ carpal tunnel \_\_\_\_\_

\_\_\_ disc problems \_\_\_\_\_

\_\_\_ whiplash \_\_\_\_\_

\_\_\_ chronic tension headaches \_\_\_\_\_

\_\_\_ migraines \_\_\_\_\_

\_\_\_ head injury \_\_\_\_\_

\_\_\_ heart condition \_\_\_\_\_

\_\_\_ blood clots \_\_\_\_\_

\_\_\_ varicose veins \_\_\_\_\_

\_\_\_ high/ low blood pressure \_\_\_\_\_

\_\_\_ sinus problems \_\_\_\_\_

\_\_\_ allergies \_\_\_\_\_

\_\_\_ asthma \_\_\_\_\_

\_\_\_ emphysema \_\_\_\_\_

\_\_\_ other \_\_\_\_\_

\_\_\_ rashes \_\_\_\_\_

\_\_\_ athletes foot \_\_\_\_\_

\_\_\_ psoriasis/eczema \_\_\_\_\_

\_\_\_ ulcers \_\_\_\_\_

\_\_\_ irritable bowel syndrome \_\_\_\_\_

\_\_\_ chronic constipation \_\_\_\_\_

\_\_\_ kidney infections/disease \_\_\_\_\_

\_\_\_ crohn's disease \_\_\_\_\_

\_\_\_ fibromyalgia \_\_\_\_\_

\_\_\_ cancer/ tumors \_\_\_\_\_

\_\_\_ stroke \_\_\_\_\_

\_\_\_ diabetes \_\_\_\_\_

\_\_\_ hepatitis C \_\_\_\_\_

\_\_\_ chronic fatigue \_\_\_\_\_

\_\_\_ suppressed immune system \_\_\_\_\_

\_\_\_ insomnia \_\_\_\_\_

\_\_\_ depression \_\_\_\_\_

\_\_\_ anxiety \_\_\_\_\_

For women only:

\_\_\_ endometriosis \_\_\_\_\_

\_\_\_ fibroids \_\_\_\_\_

\_\_\_ pregnancy \_\_\_\_\_

I have stated all medical conditions that I am aware of and will update my therapist of any changes in my health. I understand that massage treatments are my personal financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been made. I will provide **Caroline Brady LMP**, with at least **24 hours notice** if I need to cancel or reschedule an appointment. I understand that I will be charged in full for any appointment broken with less than **24 hours notice**.

Signed \_\_\_\_\_ Date \_\_\_\_\_