Personal History

All information in this questionnaire is STRICTLY CONFIDENTIAL

Name: ______ Date of Birth: ______

Address: ______ Today's Date: ______

City: ______ State: ______ Zip: ______

Telephone: Home ( ) ______ Work ( ) ______ Occupation: ______

Email: ______

Who may we thank for referring you to Health Options? ______

Have you ever received a professional massage? Yes ☐ No ☐

If yes, frequency: ______ Date of last massage: ______

Medical

Within the past year, have you been under the routine care of a health provider(s) including physician, chiropractor, alternative practitioner, psychotherapist, etc? If so, please explain:

______

______

Name of practitioner: ______

List of current medications, including aspirin, ibuprofen, etc. ______

______

______

______

Rate yourself in the following areas:

	Excellent	Good	Fair	Poor
Overall physical health	1	2	3	4
Overall mental health	1	2	3	4
Diet	1	2	3	4
Water intake	1	2	3	4
Exercise routine	1	2	3	4

List stress reduction and exercise activities. Include frequency. ______

______

Please list previous health history in the following areas (include year and treatment received).

Surgeries: ______

Accidents: ______

Diagnosed Conditions: ______

______

______

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