

CROW MEDICINE CLIENT HEALTH HISTORY FORM

110 S Jackson St, Moscow ID, (208) 301-1804

www.crowmedicine.net

Name: _____ DOB: _____ Male / Female: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____

Email: _____ Occupation: _____

Referred by: _____

Please list an emergency contact: _____

Contact number: _____ Relationship to Patient: _____

Are you currently under the care of an MD _, DC _, PT_, OT _ _, other: _____

Referring Physician? _____ Physician's number: _____

Permission to consult with referring Physician? **Yes / No.** Please initial if yes: _____

Has there been a medical diagnosis? **Yes / No.** If yes, what was the diagnosis? _____

Are you presently taking any prescription medication or supplements? **Yes / No.**

If yes, what type? _____

Please list (date and description) any significant accidents or surgeries: _____

What is your major area of concern today? _____

When did this first occur? What brought it on? _____

What activities or movement aggravate the condition? _____

Is the condition getting worse? **Yes / No**. What makes it feel worse / better? ___

Does it interfere with work? **Y / N**. Sleep? **Y / N**. Daily activities? **Y / N**. Recreation? **Y / N**.

What have you done to get relief? _____

Please describe your exercise activities: _____

What are your expectations / goals for this visit? _____

Please check the following conditions that apply to you, write 'past' or 'p' if no longer a concern.

Please add your comments to clarify the condition if necessary:

Musculoskeletal

- | | | |
|---|---|---|
| <input type="checkbox"/> Joint stiffness / swelling | <input type="checkbox"/> Spasms / cramps | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Strains / sprains | <input type="checkbox"/> Jaw pain / TMJD |
| <input type="checkbox"/> Broken / fractured bones | <input type="checkbox"/> Tendinitis | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Thoracic Outlet Syndrome |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Herniated / bulging disk. | | |

Skin

- | | | |
|---|--------------------------------|--|
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Warts | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Moles | <input type="checkbox"/> Pressure sores |
| <input type="checkbox"/> Herpes simplex | <input type="checkbox"/> Acne | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Skin allergies | <input type="checkbox"/> Boils | <input type="checkbox"/> Fungal infections |

Circulatory / Respiratory

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Dizziness / Fainting |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Asthma |

- Blood clots / DVT
- Thrombophlebitis
- Varicose veins
- Anemia

- Raynaud's Syndrome

- Sinusitis
- Tuberculosis
- Emphysema
- Allergies

Digestive

- GERD (reflux)
- Irritable Bowel Syndrome
- Crohn's Disease

- Indigestion
- Diarrhea
- Constipation

- Intestinal gas / bloating
- Hepatitis
- Cirrhosis

Lymph / Immune / Endocrine

- Edema
- Lupus
- Chronic Fatigue Syndrome

- Leukemia
- Lymphoma
- HIV / AIDS

- Diabetes
- Hypothyroid
- Hyperthyroid

Nervous

- Parkinson's Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Post / Polio Syndrome

- Bell's Palsy
- Cerebral Palsy
- Numbness / tingling
- Neuritis

- Reduced sensation
- Seizure disorders
- Sleep disorders
- Depression

Reproductive / Urinary

- Hysterectomy
- Pelvic Inflammatory Disease
- Bladder infection

- Endometriosis
- Ovarian Cysts
- Pregnant

- Breast Cancer
- Prostate Cancer

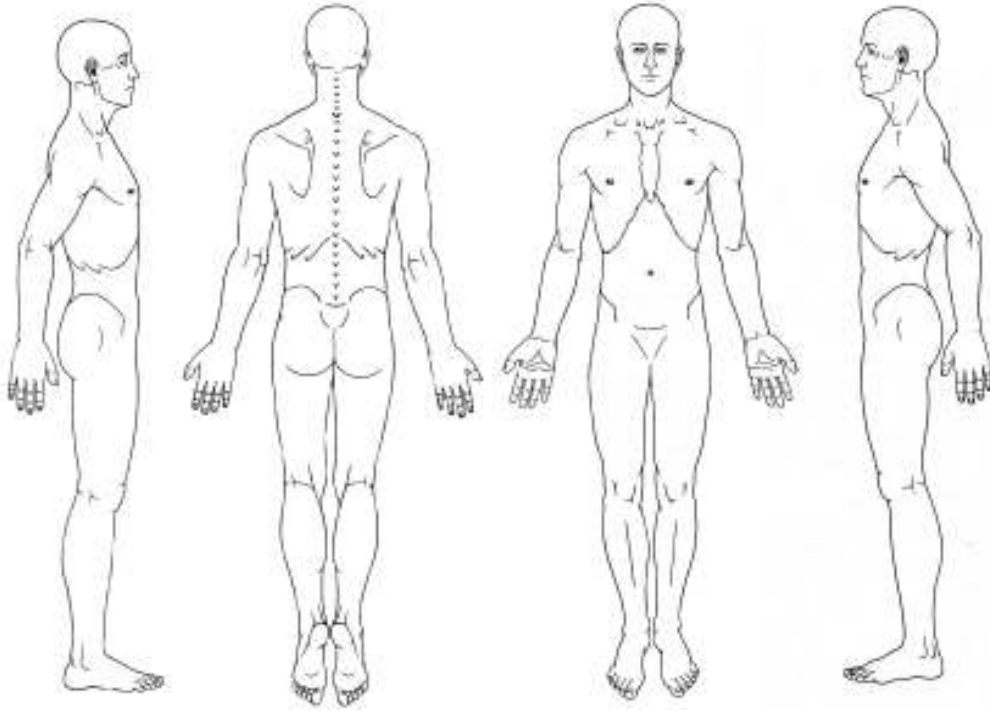
Other

- Drug use: _____
- Nicotine use: _____
- Other: _____
- Alcohol use: _____
- Caffeine use: _____
- Hearing impaired: _____
- Visually impaired: _____

List any previous motor vehicle accidents below:

Client Status Diagram

Please carefully shade on the body outline below, any areas that are currently causing you pain or discomfort, and rate the severity of the symptoms in those areas on a 0 - 10 pain scale



0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Discomforting Distressing Horrible Worst Pain

Consent for Care

It is my choice to receive Massage Therapy. I am aware of the benefits and risks of Massage Therapy, and give my consent for care. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that Massage Therapy is not a substitute for medical examination and diagnosis, medical treatment or medications.

I have informed the Licensed Massage Practitioner (LMP) of all my known physical conditions, medical conditions and medications, and will inform the LMP of any changes in my health status. I understand that there shall be no liability on the LMPs part due to my forgetting to relay any pertinent information.

Client's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____