Andrea Lorentz HonBA, RMT, CMRP ◊ Health History

WELCOME! I would like to make your appointment as pleasant & comfortable as possible. If at any time you have questions regarding your session, please let me know. If any of the following information changes at any time (health or contact info), please update me at your next visit.

Name _____ Date of Birth _____ Age _____

Address _____

Cell Phone _____

Email _____ Occupation _____

Family Doctor _____ City _____

Emergency Contact & Relationship_____ Phone _____

♦ Describe Your Main Complaint:

_____

_____

♦ Have you ever received Treatment by any of the following for this complaint or other issues?

☐Massage Therapist ☐Medical Doctor ☐Physiotherapist
☐Chiropractor ☐Osteopath ☐Other _____

♦ Current **Medications & Supplements** (Incl. over the counter drugs) & the condition it is taken for:

Name:_____ Condition: _____
Name:_____ Condition: _____
Name:_____ Condition: _____
Name:_____ Condition: _____
Name:_____ Condition: _____

♦ List all: surgeries, major infections, Motor Vehicle Accidents, fractures, hernia, etc.

	Date Occurred	**Current Symptoms** (if any):
1. _____	- _____	- _____
2. _____	- _____	- _____
3. _____	- _____	- _____
4._____	- _____	- _____
5. _____	- _____	- _____
6. _____	- _____	- _____

Current Symptom: use ✓ **Past Symptom: circle box** ☐

Pain / Stiffness / Swelling

☐Upper Back ☐Hip ☐Neck ☐Elbow ☐Tendonitis/Bursitis
☐Mid Back ☐Knee ☐Shoulders ☐Wrist ☐Carpal Tunnel Syndrome
☐Low Back ☐Ankle ☐Arm/Hand ☐Other _____

Head/Spine

□Headache: Frequency_____ Location_____ □Migraines
□Sciatica: left/right □Degenerated Disc(area)_____ □Herniated Disc(area)_____
□Fracture(area)_____ □Whiplash(yr)_____ □Pinched nerve(area)_____
□Pins,wires,artificial joints(area)_____ □Scoliosis (upper, mid, lower)

Respiratory

□Pneumonia □Bronchitis □COPD □Sinusitis □Shortness of Breath
□Emphysema □Asthma □Smoking □Other _____

Skin

□Psoriasis □Eczema □Warts □Plantar Warts □Bruise Easily
□Hemophilia □Loss of Sensation_____
□Contagious Conditions _____ □Skin Sensitivities/Allergies_____

Cardiovascular

□High Blood Pressure □Low Blood Pressure □Heart Attack(date)_____
□Stroke_____ □Pace Maker □Poor Circulation □Angina
□Diabetes □Phlebitis □Anemia □Deep Vein Thrombosis
□Congestive Heart Failure □Varicosities □Other _____

Digestive / Urinary

□Poor Digestion □Crohn's / Colitis □Irritable Bowel □Bladder □Ulcers
□Prostate □Constipation □Liver/Gall Bladder □Kidney

Infectious Diseases

□TB □Hepatitis___ □HIV/Aids □Herpes/Cold Sore □Other_____

Female

□Menstrual Cramps □Menopause □ C-Section □Natural Childbirth □Pregnant(due)_____

Other Conditions

□Osteoporosis □Cancer □Epilepsy □Fibromyalgia □Anxiety/Depression
□Multiple Sclerosis □Allergies _____ □Cerebral Palsy
□Arthritis Osteo / Rheumatoid(areas)_____

Additional Notes & Other Conditions, please elaborate:

Mark areas of pain, numbness/tingling, swelling, loss of movement: