Email Member: Yes | No
Mailing List Member: Yes | No
Online Scheduler Access: _______________
Date Processed: _____________
Internal Use Only

Health History

Name ___________________________________ Date _________________

Address _________________________ Town/City ____________________

State ____ Zip Code __________ Email _____________________________

Phone (H) _______________ (W) _______________ (C) _______________

Referred By ____

Online Scheduling Access: ____ Y _____ N eNewsletter: ___ Y ____ N

(Please Supply Email address as your username, password, and access link will be supplied via-email)

In Case of Emergency Contact Person:

Name ___________________________________ Relation ______________

Phone (H) _______________ (W) _______________ (C) _______________

Medications - include any prescribed, over the counter, herbs, vitamins, supplements, ect. Use abbreviations key to describe usage in the chart below

Usage Code Key:

(D) daily (AN) as needed/necessary (ST) daily but short term

(DSC) daily but specific to certain condition (please provide short description)

Medication/ Supplement	Usage Code	What is this med/supplement treating?

More Health Questions (1)

1. Have you had a massage before? _________

   1a. If so, what type? ____________________

   1b. How long since your last massage? ______________

   1c. What brought you to Morgans Orthopedic and Sports Massage? _

   ____

2. What is your reason for this visit? ____________________________

3. What results do you expect from this treatment? _________________

4. Have you had any past or recent diagnosed issues (physical or psychological)? If so, please give short description. ______________

   ____

5. Have you had any recent acute injury (past 6 months)? If so, please give short description. ______________________________________

6. Do you have any chronic pain? _________

   6a. If so, where? ____

   6b.When did the problem begin? _____________________________

   6c. what do you do to treat it? _______________________________

   6d. when does it occur (time or activity)? ______________________

   ____

7. Describe any surgery you have had: ___________________________

   ____

8. What are your exercise/sporting habits? ________________________

   ____

9. Do you have any tense/sore areas that need special attention? _______

   9a. If so, where? ____

More Health Questions (2)

Circle any of the following conditions you may have or have had:

Allergies	Depression	Phlebitis/Blood
Arthritis	Diabetes	Pins/Pacemaker
Anemia	Digestion Problems	Pregnancy
Anxiety	Dizziness/Fainting	Psychiatric
Asthma	Endocrine Issues	Recent Surgery
Bleeding/Bruising	Fatigue	Respiratory
Blood Clots	Headaches	Seizures/Epilepsy
Blood Pressure Problem	Hepatitis	Sinus Problems
Bursitis	Hernia	Skin Conditions
Cancer	Joint Problems	Smoker
Cardiac Issues	Kidney/Urinary	Stress
Circulation Problems	Liver/Gall Bladder Neuritis	Ulcers
Cold Sweats	Muscle Strain/Sprain	Varicose Veins
Contact Lens	Osteoporosis	Vertebral/Disc Issues

10. Describe any other conditions, syndromes, recent accidents, and anything else pertinent to your health status: ____________________

____

11. Please explain any circled conditions above: ____________________

____

____

____

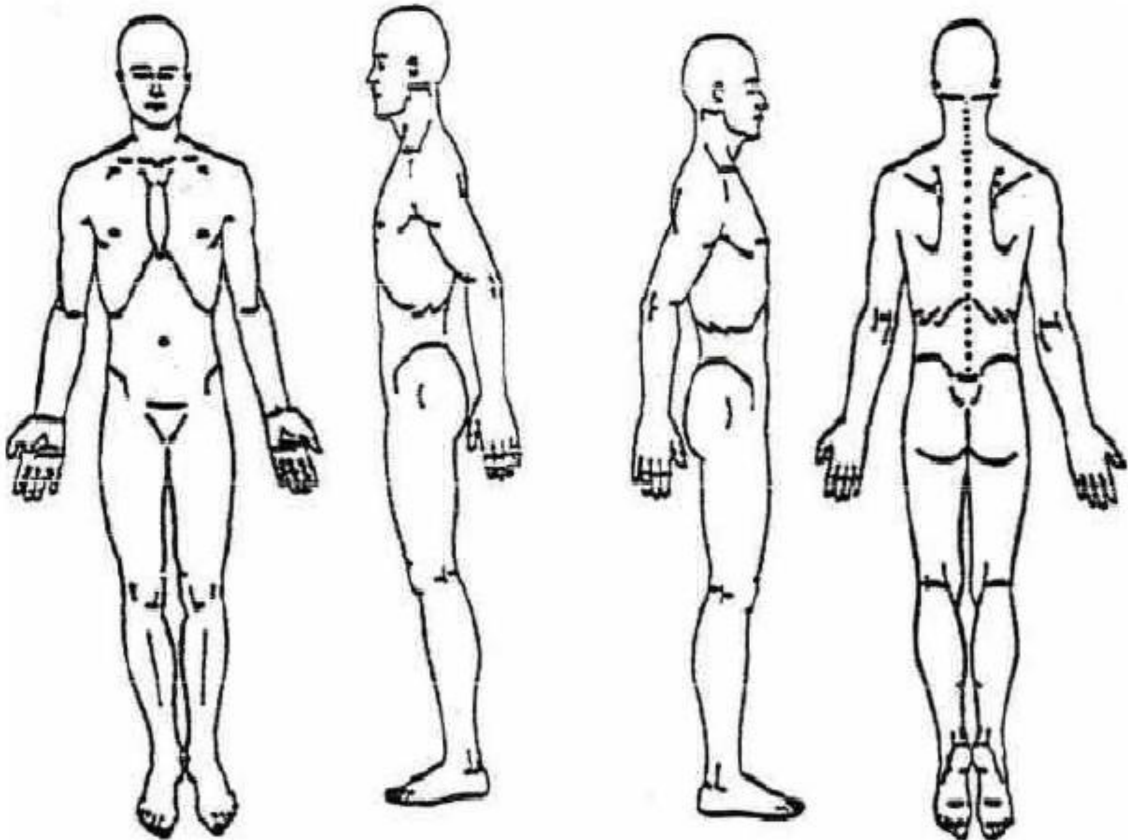
____

____

____

The Pain & Tension Chart

Please mark on the drawings below where your pain is and where you hold your tension



Thank You For Your Generosity

*Morgans Orthopedic & Sports Massage pledges to hold your information in the strictest of confidence and promises to only use the information provided to help create a treatment plan for the intended client

Client Signature _______________________________ Date _________

Client Printed Name ____

Therapist Signature ____

Therapist Printed Name _______________________________________