

Fusion Therapeutics Health History Form

Name: _____	Date: _____
Address: _____ _____	Phone (res): _____ (bus): _____ (cell): _____
Date of Birth (mm/dd/yy): _____	Email: _____
Primary Care Physician & Number : _____	
How did you hear about us? _____	

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidential except as required or allowed by law or to facilitate diagnosis (assessments) or treatment. You will be asked to provide written authorization for release of any information.

What is your primary reason for receiving massage therapy? (Please be as specific as possible)

How long have you had this condition? _____

Check the boxes that best describes the quality of your pain:

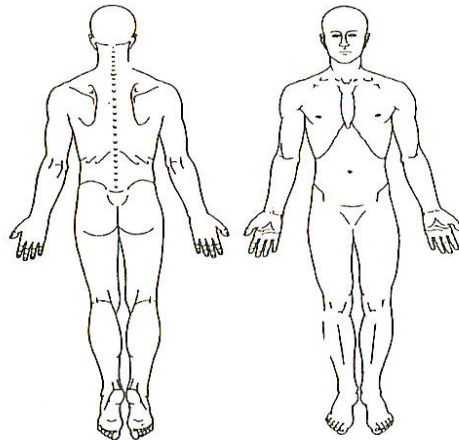
- | | | |
|--------------------------------------|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Not Local |
| <input type="checkbox"/> Deep | <input type="checkbox"/> Shooting | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Superficial | <input type="checkbox"/> Burning | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Constant | <input type="checkbox"/> Localized | <input type="checkbox"/> Throbbing |

On a scale of 0 (no pain) to 10 (worst pain) where do you feel your current level of pain lies?

What increases your pain? _____

What decreases your pain? _____

On the diagram provided, please indicate where you feel the pain or tenderness with an X, numbness or tingling with a Y.



What goals do you wish to achieve with massage therapy? (Please check all that applies)

- | | |
|---|---|
| <input type="checkbox"/> Relaxation, stress relief | <input type="checkbox"/> Prevent reoccurrence of injury or symptoms |
| <input type="checkbox"/> Decrease or eliminate pain | <input type="checkbox"/> Improve health and well being |
| <input type="checkbox"/> Aid in injury recovery | |

Current Medications & Condition it treats:

Accidents/Injuries/Surgeries (please be sure to note any pins, wires, plates, artificial joints)_

(type) _____ Date _____

Please indicate the conditions you are experiencing, or have experienced:

Head/Neck		Soft tissue/Joint discomfort			
Current	Previous	Current	Previous		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck	Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	shoulders	Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	upper back	Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	low back	Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	legs	Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arms	Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other :	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis: type:	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tendonitis:	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bursitis:	_____
Respiratory		Infections			
Current	Previous	Current	Previous		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	herpes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	plantar warts	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TB	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other:	_____
Cardiovascular		Other			
Current	Previous	Current	Previous		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loss of sensation	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness/tingling	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fatigue	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	allergies	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes (type)	_____
Women					
<input type="checkbox"/>	<input type="checkbox"/>	Pregnant: Due: _____			
Number of Children: _____					
<input type="checkbox"/>	<input type="checkbox"/>	Menopause			

Other Medical Conditions: _____

As a new client, I realize that time will be spent on discussing my health history with the therapist. To ensure a safe and proper treatment, assessments will be necessary. This will be done during the scheduled time.

As a client I recognize that the therapist is working in my best interest, I understand that it is my treatment and if I do not feel comfortable with any technique that is being used I am in full control and am able to tell the therapist to stop.

To avoid a cancellation fee, 24 hours notice will be required in order to cancel any appointment. If you have any questions or comments at any point in time please do not hesitate to call.

I verify that all information is current and up to date.

Signature: _____ Date: _____