Massage at KenkoDo Clinic
735 Broadway
Somerville, MA 02144
617-666-0143

HEALTH HISTORY

Please take the time to fill out this questionnaire carefully. The information you provide will assist us in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

Name: ______________________________ Date: ____________

Address: ____

City: ____________________________ State: ________ Zip: ____________

Mobile/Home Phone: ____________________ Work Phone: ____________________

E-Mail: ____________________________ Date of Birth: ________________

Occupation: ____________________

In Emergency Notify: ____________________________ Phone: ________________

Main Complaint (*symptoms, diagnosis, duration, etc.*):

____

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____

Secondary Complaint (*symptoms, diagnosis, duration, etc.*):

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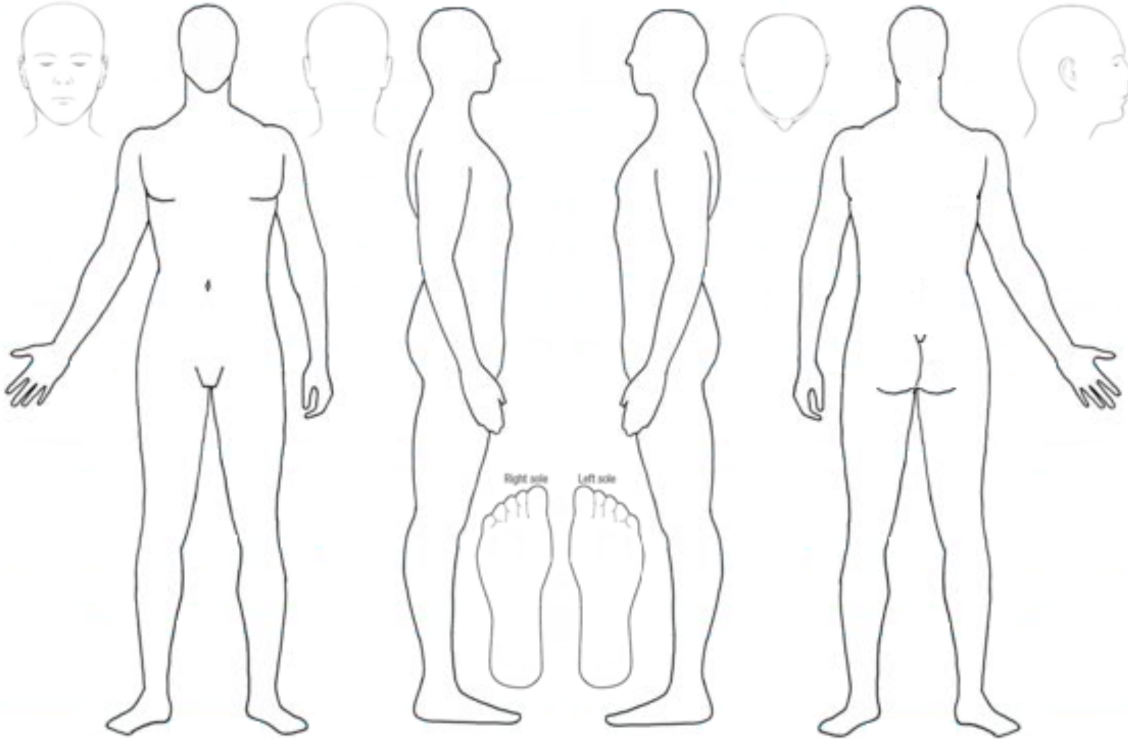
____

Please Mark Painful or Distressed Areas on the Chart Below



Surgeries (please include date of procedure)**:**

Allergies (chemical, environmental, food, drugs, etc.)**:**

Medications (names & dosages) Please attach an additional page if necessary:

Vitamins/Supplements/Herbs:

Exercise :

Days per week Length of workout Type of Activity

Diet:

Meals per day Snacks Caffeinated Drinks Alcohol per week

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, etc.):

What makes your condition worse? (Stress, fatigue, heat, certain foods, damp days etc.):

Personal History

Please check any conditions or symptoms you have now.

☐ **Arthritis**	☐ **Liver/Gall Bladder Disease**	☐ **Stroke**	☐ **Heart Disease**
☐ **High/Low Blood Pressure**	☐ **Hypo/Hyperglycemia**	☐ **Kidney Disease**	☐ **Elevated Blood Cholesterol**
☐ **Cancer**	☐ **Diabetes**	☐ **Food Allergies/Intolerance**	☐ **Diverticulitis/IBS**
☐ **Ulcer**	☐ **Seizures**	☐ **Hepatitis**	☐ **Raynaud's Disease**
☐ **Chronic Fatigue**	☐ **Anemia**	☐ **Thyroid Imbalance**	☐ **Respiratory Allergies**
☐ **Alcoholism**	☐ **Lyme Disease**	☐ **Chronic Pain Condition**	☐ **Impotence**
☐ **Gastritis/Pancreatitis**	☐ **Asthma**	☐ **Infertility**	☐ **Emphysema**

Please **check** if you have had any of these items listed below in the last **year**.
Put a **star** on the box if you had this in the past but do not any longer.

Musculoskeletal

☐ **Neck pain**	☐ **Shoulder pain**	☐ **Hand/wrist pain**	☐ **Carpal Tunnel**
☐ **Knee pain**	☐ **Sprains/Strains**	☐ **Sciatica**	☐ **Foot/ankle pain**
☐ **Hip pain**	☐ **Muscle pain**	☐ **Muscle weakness**	☐ **Tendonitis**
☐ **Back pain Low ____ Middle ____ Upper ____**		☐ **Bursitis**	☐ **Rotator Cuff**

☐ **Soreness/weakness in lower body (back, knee, hip, ankle, foot)**

Neuropsychological

☐ **Seizures**	☐ **Loss of balance**	☐ **Vertigo/Dizziness**	☐ **Areas of numbness**
☐ **Lack of coordination**	☐ **Poor memory**	☐ **Concussion**	☐ **Depression**
☐ **Anxiety/Panic attacks**	☐ **Bad temper/irritable**	☐ **Easily susceptible to stress**	☐ **Seasonal Affective Disorder**
☐ **Nervousness**	☐ **ADD/ADHD**	☐ **Manic Depression**	

Have you ever been treated for emotional problems? ☐ **Yes** ☐ **No**
Have you ever considered or attempted suicide? ☐ **Yes** ☐ **No**
Have you ever been treated for substance abuse? ☐ **Yes** ☐ **No**

Please read, sign and date:

It is my choice to receive massage therapy. I understand that it is my right, as well as the right of the massage therapist to refuse receiving or facilitating treatment. I realize that the treatment is being giving for the well-being of my body and mind. I realize this treatment is of a strictly clinical, non-sexual nature. I agree to communicate with my practitioner any time I feel like my well-being is being compromised.
Because massage should not be provided under certain medical conditions, I affirm that I have stated all physical or mental ailments that I am aware of and will update the practitioner of any changes in my health status. I understand that massage is not a substitute for medical examination, diagnosis, or prescription of pharmaceuticals and that I should see a primary health care provider for those services.

*Client signature:*____*Date:*__________________