PAMELA LOCH BA (HONS), DIP. C.M.T., ITEC
CLINICAL MASSAGE THERAPIST

t +44 (0) 7557 409175
e mail @clinicalmassageglasgow.co.uk
w www.clinicalmassageglasgow.co.uk

HEALTH HISTORY FORM - CONFIDENTIAL

NAME _____ M / F
ADDRESS _____
_____
POSTCODE _____
HOME PHONE _____ MOBILE _____
EMAIL _____
OCCUPATION _____
D.O.B _____ REFERRED BY: SELF FRIEND INTERNET OTHER

Please tick conditions you are experiencing and circle conditions you have experienced in the past

SKIN:
- ☐ rashes/bruise easily
- ☐ infectious skin conditions:

_____

- ☐ other: _____

MUSCLES/JOINTS:
(Indicate Left [L] or Right [R] where appropriate).
- ☐ neck
- ☐ upper back
- ☐ mid back
- ☐ lower back
- ☐ shoulder
- ☐ elbows
- ☐ arm
- ☐ wrist
- ☐ hand
- ☐ hip
- ☐ leg
- ☐ knee
- ☐ ankle
- ☐ foot
- ☐ weakness or loss of strength
- ☐ clumsiness
- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ other arthritis: _____

_____

- ☐ osteoporosis
- ☐ tendonitis: _____
- ☐ location _____ date _____
- ☐ strain: _____
- ☐ location _____ date _____
- ☐ joint sprain/dislocation: _____
- ☐ location _____ date _____
- ☐ other injury: _____
- ☐ location _____ date _____

RESPIRATORY:
- ☐ asthma
- ☐ bronchitis
- ☐ chronic cough
- ☐ difficult breathing
- ☐ emphysema
- ☐ shortness of breath
- ☐ smoking
- ☐ other:

CARDIOVASCULAR:
- ☐ bleeding disorder
- ☐ high blood pressure: _____

_____

- ☐ low blood pressure: _____

_____

- ☐ heart attack
- ☐ heart disease
- ☐ angina
- ☐ stroke/cererovascular accident
- ☐ pacemaker
- ☐ varicose veins
- ☐ phlebitis
- ☐ poor circulation
- ☐ other:

_____

_____

HEAD/NECK:
- ☐ visual impairment: _____

_____

- ☐ hearing impairment: _____

_____

- ☐ speech impairment: _____

_____

- ☐ headache/migraine
- ☐ jaw pain (temporomandibular joint [TMJ] pain)
- ☐ sinus problems

GI CONDITIONS:
- ☐ constipation
- ☐ diarrhea
- ☐ irrtable bowel: _____

_____

- ☐ hiatus hernia
- ☐ ulcers

OTHER CONDITIONS:
- ☐ allergies
- ☐ cancer
- ☐ diabetes
- ☐ fainting
- ☐ fever
- ☐ insomnia
- ☐ numbness/tingling
- ☐ seizures
- ☐ stress

INFECTIOUS CONDITIONS:
- ☐ hepatitus
- ☐ HIV
- ☐ TB

FRACTURE: no yes
location _____ date _____
SURGERY: no yes
for what? _____ date _____
MOTOR VEHICLE ACCIDENT:
no yes
symptoms _____ date _____
MEDICATIONS currently taken:
(This includes prescription drugs, over-the counter and supplements):

_____

_____

Are you in the first 12 weeks of pregnancy?
no yes
Weekly exercise 1-2, 3-4, 5+ times a week?

Present injury, pain or movement difficulties?: _____

_____

_____

Have you ever had this condition or something similar before? no yes date _____
Aggravating factors?: _____
Relieving factors?: _____
On a pain scale of 0 - 10 (10 being the worst), how would you rate your pain/discomfort?: _____
Is there anything else in your health history I should know about?: _____

_____

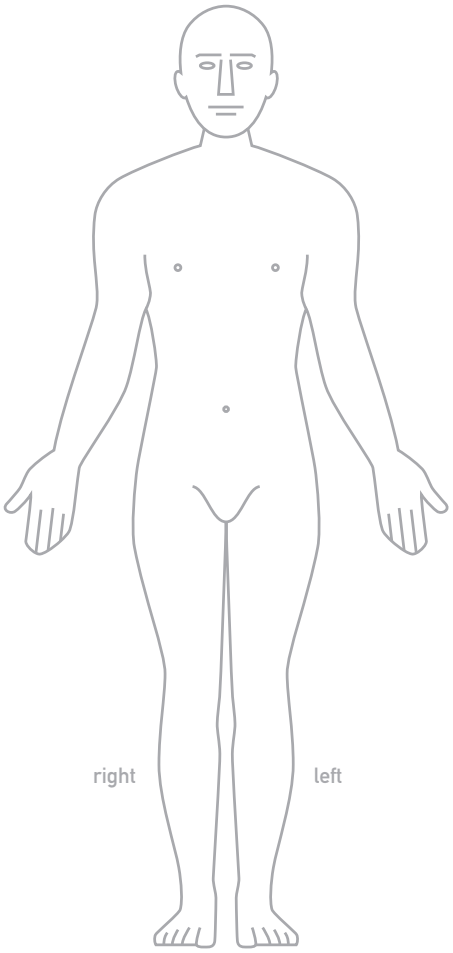
_____

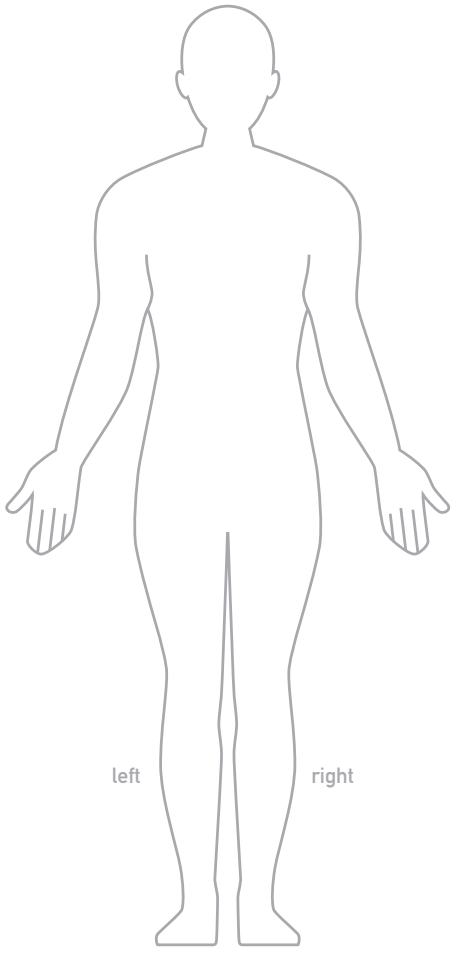
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on the diagram where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
- - - - - - -	0 0 0 0 0 0	X X X X X X	* * * * * *	/ / / / / /

Please mark on the pain scale from 0 - 10 the pain you feel with this condition.
0 being no pain, 10 being the worst pain you have felt with this condition.





HEAD & NECK
Pain: 0 1 2 3 4 5 6 7 8 9 10

UPPER BACK
Pain: 0 1 2 3 4 5 6 7 8 9 10

MID BACK
Pain: 0 1 2 3 4 5 6 7 8 9 10

LOWER BACK
Pain: 0 1 2 3 4 5 6 7 8 9 10

LEGS & FEET
Pain: 0 1 2 3 4 5 6 7 8 9 10

DATE_____ **SIGNATURE**_____