Health History Form - Rossiter

Integrative Massage of Boulder

(All information will be kept confidential)

Name ______________________ Date of Birth [ ][ ] [ ][ ] [ ][ ] (M M D D Y Y)

Address ______________________ City ______________ State ______ Zip __________

Phone ______________________ Email address ______________________

Occupation ______________________ How did you hear about Rossiter? ______________

Emergency contact information:

Name & Relationship: ______________________ Phone ______________

Health Questions

Has your doctor given you any restrictions regarding exercise or activity?

____

Pain medication / NSAIDs? ______________________

Surgeries? ______________________

Cortisone shots? ______________________

Can you safely get up and down from the floor without assistance? ______________

Do you have or have you had cancer? ______________________

Additional Information

During my average day I mostly:

( ) sit in front of a computer
( ) stand on my feet
( ) do a variety of activity

Additional daily activities:

____

Difficulty with exercise* (explain below)

____

Please mark as it applies to you:

( ) have had a stroke
( ) recent injury*
( ) light-headedness, fainting, vertigo
( ) Rheumatoid arthritis
( ) Multiple sclerosis
( ) Pregnant or may be pregnant
( ) High blood pressure
( ) Epilepsy
( ) Breast implants

Client's Signature ______________________ **Date** ______________

By signing this form I confirm that I have read and fully understand all of its contents and I have answered every question completely & accurately.