

Confidential Health Background Form

Infusion Massage & Bodywork
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Would you like to receive an Infusion Massage email newsletter of health and wellness tips? _____
Would you like to receive an email newsletter of digestive health and food allergy tips? _____

General Policies

- Payment is due at the time of treatment.
- A cancellation or schedule change should be made at least 24 hours in advance of the appointment, otherwise full payment is still due; except in case of extreme emergency.

Contact Information

Name _____ Date _____
Address _____ City _____ State _____ Zip _____ Phone _____
Numbers: _____ (cell) _____ (home) _____ (work)
Email _____
Do you have a preferred method of communication? _____
Birthday ____ / ____ / ____ Gender _____ Height _____ Weight _____
Occupation _____ Marital Status _____
Emergency Contact:
Name: _____ Relationship: _____ Phone: _____

Referred by: _____

Reason for Visit

What is your primary issue? _____
When did you first notice it? _____ Do you know what brought it on? _____
Describe anything that could have stressed your body or mind at the time: _____

What activities provide relief? _____
What makes it worse? _____
Is your condition getting worse? _____ Is your performance at work affected? _____
Describe your sleep recently: _____
Do you have any other issues or concerns? _____

Current Health Context

List any major medical conditions including anything infectious: _____

List practitioners who are working with you on these conditions: _____

Rate your stress level on a scale of 1-10 (10 being the highest) and describe how you believe it affects your health (insomnia, irritability, muscle tension, digestive disturbances, etc.): _____

List any recent injuries and how you have been caring for them: _____

Please list any supplements or medications you are currently taking: _____

Please list any supplements or medications you used to take in the last few years: _____

Please list any traumas, emotional or physical, that you feel are relevant to your treatment and that you feel comfortable sharing at this time: _____

Describe your exercise habits, including the type and frequency: _____

Have you had massage or bodywork before? _____ What type? _____

Have you injured or fallen on your sacrum, head, or tailbone? _____

Are you sensitive or allergic to any specific oils? Including oils of apricot, olive, walnut, cocoa, jojoba or shea? _____

List any other allergies or chemical sensitivities: _____

Medical History

Primary doctor's name: _____ phone: _____

office address: _____ email: _____

Medical specialist: _____ phone: _____

office address: _____ email: _____

Surgical history (type and year): _____

Did you have surgery to remove your tonsils, adenoids, or appendix? _____

Hospitalizations: _____

Accidents or traumas: _____

Birth trauma (if known): _____

Digestion

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____ Glasses of water each day: _____ Caffeine? _____

What are the least healthy foods in your diet? _____

Are you subject to binge eating? _____ Which foods? _____

Do you experience bloating or gas or burps after eating? _____

What foods trigger this? _____

How often do you have a bowel movement? _____

Do you experience heartburn? _____ Constipation? _____ Blood in stool? _____ Mucus

in stool? _____ Pain when stooling? _____ Other _____

Emotional and Spiritual

What is your opinion of yourself? _____

If possible, describe the most negative emotion you experience: _____

When do you most often feel this emotion? _____ Where are you? _____

Describe any experience you may be having with depression or anxiety: _____

Do you pray or have a spiritual practice? _____

On a scale of 1-10 (10 being greatest) rate yourself on:

Faith _____ Hope _____ Charity _____ Sense of Humor _____ Sense of Fun _____

Fear _____ Grief _____ Other (describe briefly) _____

What hobbies and activities provide you with a sense of pleasure and accomplishment? _____

General Health History

Past	Recent	Current	<< check more than one if applicable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches (migraine, tension, cluster, caffeine)_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pain_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sleep disturbances or insomnia_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fatigue_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	very high or very low fever_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus infections or frequent colds_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loss of smell or taste_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	artificial or missing limbs_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	seizures_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	benign tumor_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	thyroid dysfunction_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other_____

Skin Conditions

Past	Recent	Current	<< check more than one if applicable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rashes_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	psoriasis or eczema_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	acne_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fungus_____

Allergies

Past	Recent	Current	<< check more than one if applicable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	detergents, soaps_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scents, oils, lotions_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chemicals_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	foods_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pets or animals_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pollen, grass (seasonal)_____

Muscles and Joints

Past	Recent	Current	<< check more than one if applicable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatoid arthritis_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	osteoarthritis_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	osteoporosis_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scoliosis_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	broken bones_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	spinal problems_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	disk problems_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lupus_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TMJ or jaw pain_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	spasms, cramps_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sprains, strains_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tendonitis or bursitis_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	stiff or painful joints_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weak or sore muscles_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck, shoulder, arm pain_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lower back, hip, leg pain_____

Nervous System

Past	Recent	Current	<< check more than one if applicable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	head injuries, concussions _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dizziness, ringing in the ears _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loss of memory, confusion _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness, tingling, feeling of pins and needles _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sciatica, shooting pain _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chronic pain _____

Cardiovascular and Respiratory

Past	Recent	Current	<< check more than one if applicable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart disease _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	blood clots _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	stroke _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lymphedema _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high or low blood pressure _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	irregular heart beat or heart murmur _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation (including cold hands or feet) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	swollen ankles _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	varicose veins _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain, shortness of breath _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma _____

Habits

Past	Recent	Current	<< check more than one if applicable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tobacco _____ frequency: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	alcohol _____ frequency: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	drugs _____ frequency: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	caffeine (coffee, tea, mate, chocolate, soft drinks) _____ frequency: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	soda _____ frequency: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other _____ frequency: _____

Family History

>> Describe whether each relative is alive, their age or cause of death, and any major health issues:

Mother: _____

Father: _____

Siblings: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Family history of abuse (circle if applicable): physical emotional sexual spiritual

Family history of substance abuse: _____ Suicide: _____

Health Goals

How do you feel about the state of your health? In what ways would you like to see that change?

What changes would you like to achieve in six months? _____

One year? _____

Signature: _____ Date: ____/____/____

Female Reproductive Health History

Medications your mother took when she was pregnant with you: _____

Age of first menstruation _____ What was this like for you? _____

Number of pregnancies: _____

Number of deliveries: _____ Delivery dates: _____

Number of miscarriages: _____ Dates: _____

Number of terminations: _____ Dates: _____

Complications? _____

Describe your experience with Pregnancy: _____

Labor: _____

Delivery: _____

Post partum: _____

Last pap smear: _____ Results: _____

Date of last menstruation: _____ Length of menses: _____

Have you had any episodes of amenorrhea? _____ When? _____ How long? _____

Contraception

Past Current << check more than one if applicable

- pill
- patch
- diaphragm
- injection
- condoms
- IUD
- abstinence
- rhythm method

Time on synthetic contraception (pill, patch, injection): _____

Maternal family history

- infertility
- fibroids
- endometriosis
- menstrual problems
- PMS

Reproductive Health Symptoms

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> painful periods <input type="checkbox"/> headache with period <input type="checkbox"/> painful ovulation <input type="checkbox"/> irregular periods (late or early) <input type="checkbox"/> dizziness during period <input type="checkbox"/> failure to ovulate <input type="checkbox"/> bloating or water retention during period <input type="checkbox"/> numb legs when standing still <input type="checkbox"/> endometritis <input type="checkbox"/> endometriosis <input type="checkbox"/> fibroids <input type="checkbox"/> weak newborn infants <input type="checkbox"/> dark thick blood at beginning or end of cycle <input type="checkbox"/> excessive bleeding (more than one pad an hour) <input type="checkbox"/> PMS or depression during or before period <input type="checkbox"/> heaviness or pressure in lower pelvis during period <input type="checkbox"/> vaginal discharge, describe: _____ <input type="checkbox"/> sexually transmitted disease; type and diagnosis date: _____ | <ul style="list-style-type: none"> <input type="checkbox"/> sore heals when walking <input type="checkbox"/> varicose veins in the legs <input type="checkbox"/> pelvic inflammation <input type="checkbox"/> incompetent cervix <input type="checkbox"/> painful intercourse <input type="checkbox"/> frequent urination <input type="checkbox"/> dry vagina (without menopause) <input type="checkbox"/> uterine polyps <input type="checkbox"/> vaginal yeast infections <input type="checkbox"/> uterine infections <input type="checkbox"/> bladder infections <input type="checkbox"/> vaginitis <input type="checkbox"/> difficult menopause <input type="checkbox"/> difficult pregnancy <input type="checkbox"/> premature deliveries |
|--|---|