Live Well - Massage Therapy & Osteopathy

Patient Information

Name:________________________________ Date of Birth: ____________________

Address (street, city, postal code): ____

Phone Number: Home: ______________ Cell: _____________ Work: ______________

Primary Physician: ____________________ Physician's Phone Number: _____________

Purpose for Visit

Primary Complaint: __________________________ Date of Onset: _______________

How did it happen? ____

Imaging Studies (X-Ray, MRI, Etc.): ____

Previous Treatment(s) and type: ____

____

Past Medical History

Please check if you are currently or have experienced any of the following conditions:

General

___ Headache (frequently) ___ Migraines ___ Jaw pain/clicks ___ Clenching ___Orthodontics

___ Major dental work done ___ Cancer (Type: ________________)

Bones/Muscles/Joints

___ Neck ___ Shoulders (L) (R) ___ Elbows (L) (R) ___Wrist (L) (R) ___ Hands (L) (R)

___ Upper Back ___ Middle Back ___ Low Back ___ Hips (L) (R) ___ Knees (L) (R)

___ Ankles (L) (R)___ Feet (L) (R) ___ Rheumatoid Arthritis ___ Osteoarthritis

___ Osteopenia/Osteoporosis ___ Fibromyalgia ___ Chronic Pain

Eyes, Ears, Nose, Throat

___ Vision Issues ___ Glasses/contacts ___ Eye Surgery ___ Ear Infection/Aches

___ Ringing in Ears ___ Dizziness ___ Sinus Infections/Problems ___ Deviated septum

___ Recurrent sore throat

Respiratory

___ Asthma ___ Chronic Cough ___ Emphysema ___ Seasonal allergies

___ Pneumonia ___ Shortness of Breath ___ Chronic Bronchitis

___ Colds (Frequency _________)

Cardiovascular

___ High Blood Pressure ___ Chest Pain ___ Cold Hands/Feet ___ Fainting

___ Low Blood Pressure ___ Stroke/CVA ___ Heart Attack(Date: ___________)

___ Irregular Heartbeat ___ Swelling of Limbs ___ Congestive Heart Failure

Gastrointestinal

___ Gall Bladder Trouble ___ Gas/Burping ___ Constipation ___ Rectal Pain

___ Indigestion/Acid Reflux ___ Diarrhea ___ Blood in stool ___ Weight loss

___ Nausea/Vomiting ___ Liver Issues ___ Food Allergies ___ Weight gain

___ Abdominal Cramping ___ Hemorrhoids ___ Irritable Bowel Syndrome

Endocrine

___ Thyroid (Hyper/Hypo) ___ Low Energy ___ Diabetes (Type: ______; Onset _________)

Reproductive

___ Fertility Issues ___ Prostate problems

___ Menstrual issues ___ Ovarian cysts ___ Fibroids ___ Menopausal

___ # of pregnancies ___ # of births ___ # of miscarriages ___ Date of last pap ___________

Urinary

___ Bladder infections ___ Kidney infections ___ Kidney stones

Neurological

___ Numbness/Tingling ___ Seizures/Epilepsy ___ Poor Memory ___ Concussion

___ Multiple Sclerosis (MS) ___ Loss of Balance ___ Decreased Coordination

	Car Accident(s)	**Fractures**	**Surgeries**	**Trauma Falls**
Date(s)				
Type(s)				

Medications

Please list all medications you are currently taking. Include prescription, over-the-counter, non-prescription and/or supplements.

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________