



Hudson Valley Birth & Bodywork

Date: _____

HEALTH HISTORY QUESTIONNAIRE

Please fill out this form and bring it with you to your first appointment. All questions contained in this questionnaire are strictly confidential.

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Address:			Email:
Phone	HM	WK	Cell
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Occupation:		Referred by:	
Emergency Contact:		Date of initial visit:	
Primary physician:			

HEALTH HISTORY

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	
List any medical problems that doctors have diagnosed	
Surgeries	
Type	Date
Injuries	
Type	Date
Ever received a professional massage?	
Difficulty lying on front or back?	
Session goals:	

Current medications, including aspirin & IBprofrin	
Name the Drug	Frequency Taken

Allergies
Skin conditions (Acne, Rash, Boils, Cancer, Other)

HEALTH HABITS AND DAILY ROUTINE

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.				
Exercise	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Active			
	Type of exercise:		Frequency:	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
H2O	Frequency:			
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		Frequency:	
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Drugs	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep	Problems sleeping?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowels	Constipation?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Dentures?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Aid?				<input type="checkbox"/> Yes <input type="checkbox"/> No

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Lateness/Cancellation Policy

It is understood that a situation may arise where it becomes necessary for you to be late or cancel an appointment. In fairness to all clients, the following policy has been implemented in regard to cancellations:

24 hours advanced notice—No Charge

Less than 24 hours notice:

First time- no charge

2 or more times- full fee

In the event of lateness the client is financially responsible for the full session based on the time booked for the appointment.

I understand and accept the conditions concerning lateness and cancellations.

Date

Signature