Aligned *for* Motion

Bodywork • Movement • Fitness • Ergonomics

Phone: (978) 505-9401
ShirleyLynch.com

HEATH HISTORY FORM

Date:

First Name:

Last Name:

Email Address:

Home Phone:

Work Phone:

Mobile Phone:

Address:

City:

State:

ZIP:

Date of Birth:

Referred By:

Emergency Contact

First Name:

Last Name:

Relationship:

Email Address:

Home Phone:

Work Phone:

Mobile Phone:

Please describe your pertinent medical history by answering the following questions in as much detail and with dates if possible. In order for me to design a safe and effective program tailored to your interest, it is important that you complete the form to the best of your ability. The information will be used for need determination only, not diagnosis.

Do you have allergies (drug, food, environmental)? If yes, please explain.

Have you ever been diagnosed with a condition or illness such as: Diabetes, COPD, congestive heart failure, high blood pressure, varicose veins, blood clotting disorder, pitted edema, arthritis, infections, or contagious diseases? Please list and explain as massage may not be indicated for the above conditions.

Describe any illnesses or injuries, including dates when possible:

Describe any broken bones or surgeries, including dates when possible:

What have physicians or practitioners provided in terms of diagnosis or treatment?

Check any of the following that apply to your personal medical history (please supply dates when possible):

- ☐ Eyeglasses/Contact lenses
- ☐ Orthodontics (head gear/braces)
- ☐ Orthotics (feet/shoes)
- ☐ Xrays
- ☐ Injections
- ☐ Stitches
- ☐ Arm sling
- ☐ Cast
- ☐ Crutches
- ☐ Cane
- ☐ Braces (neck, back, leg, etc.)

Are you taking any medication or drugs? If yes, please list medications and for what condition.

What is your occupation?

Do any activities that you perform while working or in other aspects of your life cause you discomfort, strain or pain?

Describe areas of your body where you are experiencing pain, stress, fatigue, or restricted movement:

What factors or activities seem to easily aggravate this problem?

What would you like to focus on in your sessions? For example, posture, movement, pain relief, specific help with movement (such as fitness or athletic performance, help with bending or sitting etc.) stress relief, enhanced body awareness, relaxation?

What other kind of medical care or body disciplines are you currently involved in, if any, and with whom?

Is there anything else that you would like your practitioner to know about your history, specific problems, or goals?

Do you understand that massage/ Aston-Patterning®/ Aston® Kinetics/ Zero Balancing®/ Sensory Enhanced Yoga® is not a medical procedure and is not a substitute for medical diagnosis?

☐ **Yes**, I understand.

By submitting this form, you certify that the above information is true and accurate to the best of your knowledge and you give permission to proceed with a massage/ Aston-Patterning®/ Aston® Kinetics/ Zero Balancing®/ Sensory Enhanced Yoga® session(s).

Name:

Your Signature: