Root & Branch
HEALING

MEDICAL HISTORY FORM

NAME:

BIRTHDATE/AGE:

TODAY'S DATE:

PHONE:

EMAIL:

MAILING ADDRESS:

SEX:

PREFERRED PRONOUN:

EMERGENCY CONTACT (name/phone):

Referred by:

Seeking Treatment for:

Onset date:

Has any treatment helped this (these) condition(s)? Please list:

What makes it worse?

What makes it better?

Have you ever received a massage before? ☐ yes ☐ no

Please list any pharmaceutical drugs or herbs you are currently taking:

Please list any injuries and/or surgeries you have had (month/year):

Please check all that apply:

☐ Chills

☐ Fever

☐ Low energy/fatigue

☐ Night sweats

☐ spontaneous sweating

☐ heat aversion

☐ cold aversion

☐ recent weight loss

☐ recent weight gain

☐ get sick easily (how often?)_____

PAIN:

☐ soreness

☐ dull

☐ sharp

☐ inflamed/swollen

☐ radiates (where?: _____)

☐ better with cold

☐ better with warmth

☐ worse in damp weather

☐ repetitive stress injury

☐ result of accident (what type, when:

_____

EARS/EYES:

☐ floaters

☐ blurry vision

☐ pain behind eyes

☐ dry eyes

☐ inflamed/red eyes

☐ cataracts

☐ glaucoma

☐ infections

☐ earaches

☐ ringing/tinnitus in ear

☐ discharge from ear

☐ other:_____

HEADACHES:

☐ headaches, which area (front, sides, back of head etc:) _____

☐ migraines, how often: _____

☐ tight band headaches

☐ sharp headaches

☐ dull headache

☐ nausea with headache

☐ Other: _____

RESPIRATORY:

☐ asthma

☐ shortness of breath

☐ difficulty exhaling

☐ tightness in chest

☐ feels like something is stuck in throat

☐ phlegm in lungs (color: _____)

easy to bring up phlegm? ☐ yes ☐ no

☐ coughing blood

☐ hoarse voice

☐ voice loss

☐ pneumonia

☐ allergies

☐ sinus congestion

☐ runny nose (color: _____}

☐ lost sense of smell

☐ other:

_____

CARDIOVASCULAR:

☐ chest pain/angina

☐ feel heart flutter (palpitations)

☐ high blood pressure

☐ low blood pressure

☐ irregular heartbeat

☐ pain under ribs

☐ cold hands and/or feet

☐ poor circulation

☐ ankle swelling

☐ history of heart attack/failure

☐ other:

_____

GASTROINTESTINAL:

☐ hard time swallowing

☐ bloating

☐ gas

☐ burping

☐ tight abdomen

☐ constipation

☐ diarrhea

☐ burning sensation

☐ blood in stool

☐ black stool

☐ undigested food in stool

☐ irritable bowel syndrome

☐ gout

☐ hemorrhoids

☐ no/low appetite

☐ insatiable appetite

☐ nausea

☐ heartburn

☐ thirst

☐ Prefer hot drinks/food

☐ Prefer cold drinks/food

☐

other:_____

URO-GENITAL

☐ copious urine

☐ urgent/bladder control issues

☐ small amount

☐ cloudy urine

☐ frequent urination

☐ burning sensation

☐ blood in urine

☐ Current UTI

☐ History of UTI

☐ genital pain/swelling

☐ genital sores

☐ impotence

☐ low sexual energy

☐ yeast infections/candida

☐ Other:

_____

NEUROLOGICAL:

☐ numbness

☐ tingling

☐ pins and needles

Location of symptoms: _____

☐ tremors

☐ drowsiness

☐ fainting

☐ vertigo

☐ paralysis

☐ stroke

☐ seizure

☐ loss of balance

☐ dizziness

☐ Other:

_____

SKIN/HAIR:

☐ acne

☐ eczema/psoriasis

☐ oily skin

☐ dry skin

☐ bruise easily

☐ dark circles/bags under eyes

☐ sores/lumps

☐ brittle nails

☐ hair loss

☐ dry scalp

Specific areas:

_____

EMOTIONS:

☐ anxiety

☐ anger

☐ depression

☐ difficulty concentrating

☐ fear

☐ nightmares

☐ irritability

☐ insomnia

☐ trouble going to sleep

☐ trouble staying asleep

(when do you wake? _____)

☐ other:

_____

MENSTRUATION: (if applicable)

Age at onset of menses: _____

Length of cycle (ie: every 28 days) _____

Number of pregnancies: _____

Number of births: _____

Blood quality:

☐ dark purple

☐ bright red

☐ pale/pink

☐ clots

☐ scanty

☐ heavy

Other Signs/Symptoms

☐ premenstrual tension

☐ constipation/diarrhea before or during menses

☐ fatigue before or during menses

☐ painful menses

☐ fibroids

☐ ovarian cysts

☐ endometriosis

☐ abnormal PAP

☐ uterine prolapse

☐ hysterectomy

☐ C-section

☐ breast tenderness

☐ breast lumps