



Integrated Health Solutions

Bodywork Symptom Survey

Name _____ Age _____ Date _____

How would you rate your present state of health? Excellent ___ Good ___ Fair ___ Poor ___

Are you currently under a doctor's care? If so, please explain: _____

Are you pregnant? Y N If yes, how far along?

Have you had bodywork before? Y N

If so, which therapy and how often? _____

Reason for today's visit? _____

Describe any surgeries, accidents or injuries you have had less than 3 years ago _____

More than 3 years ago _____

Do you have any chronic ongoing pain or stress? Y N Please explain _____

Please check any conditions that you have or have had in the past:

- | | | |
|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Muscle/joint pain | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Skin conditions | <input type="checkbox"/> High/low blood pressure |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Pregnant |

Please describe these conditions _____

Type of recreation and exercise _____

List all medications you are currently taking _____

Signature (Patient/Parent/Guardian)

Date

Rev 6/4/2018