Laurie Di Giulio, Movement & Manual Therapy
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Health History Form

The following information is private and confidential. This information helps me to better create meaningful change for you by directing me to areas of concern, and establishing potential contraindications. Please remember that this information is being collected for care not considered massage therapy, and not billable as massage therapy.

Date: How did you hear about me?

Full Name: Preferred pronouns:

Date of Birth: City/Country of Residence:

Reason for seeking care:

Please check if you have experienced in past, or currently experiencing the following:

Cardiovascular Conditions:

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ vein conditions
- ☐ cold hands/feet
- ☐ heart attack
- ☐ stroke
- ☐ any other heart/blood condition:

Respiratory Conditions:

- ☐ chronic cough, asthma, bronchitis
- ☐ smoker
- ☐ any other respiratory condition:

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Nervous System Conditions:

- ☐numbness, tingling
- ☐burning
- ☐electrical, shooting pain
- ☐loss of sensation, altered sensation
- ☐nerve impingement
- ☐concussion (diagnosed or undiagnosed)
- ☐any other nerve/brain condition:

Immune/Lymphatic System:

- ☐swelling
- ☐slow healing
- ☐easily bruised
- ☐frequent illness
- ☐any other immune/lymphatic conditions:

Digestive System:

- ☐vitamin deficiencies
- ☐ heartburn, indigestion
- ☐hiatal hernia
- ☐bloating
- ☐constipation, diarrhea
- ☐IBS
- ☐any other digestive condition:

Infections:

- ☐skin conditions
- ☐hepatitis
- ☐HIV
- ☐TB
- ☐any other infections recently:

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Reproductive:

- ☐ pregnant, indicate how many months:
- ☐ births, how many:
- ☐ menopausal
- ☐ prostate issues
- ☐ incontinence
- ☐ any other reproductive system conditions:

Other:

- ☐ jaw pain, clicking, grinding, clenching
- ☐ any pins, plates, artificial joints
- ☐ headaches, migraines
- ☐ vision loss
- ☐ hearing loss
- ☐ diabetes, type/controlled:
- ☐ epilepsy
- ☐ arthritis, type/info:
- ☐ cancer, type/info:
- ☐ allergies, to what:

Mental Health:

- ☐ My mental health is stable and good
- ☐ I have a good support system, and healthy relationships
- ☐ I'm struggling with a few things, but under control
- ☐ I'm struggling and a bit out of control
- ☐ I should get help
- ☐ I am currently under the care of a psychiatrist, psychologist etc.
- ☐ I think my mental health is linked to my physical symptoms

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Do you have any other medical conditions? (please describe)

Current Medications: (please indicate what condition they are being used to treat)

Have you had any surgeries? If so, indicate approximate date and for what issue.

Have you had any injuries/accidents? If so, indicate date and some details.

Do you have any scars? Surgical or non-surgical. Please indicate where they are located.

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What are your expectations, goals for working with me?

Have you seen other practitioners for this same issue? Any imaging (Xray, MRI) or diagnosis?

Please tell me about your diet, water intake, stress levels, lifestyle, hobbies, work:

Anything I've left out?

By signing below, you are indicating that the information provided is true and complete and that if any changes occur in your health you will inform your practitioner.

Signature: