Full Circle Fitness
EUGENE

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Eugene, OR 97401
fullcirclefitnesseugene.com

General Health History Form

Name _____ Date _____

List in order of most important to least important any pain or dysfunction you feel is present in your body:

1. _____ Date of Injury: _____
2. _____ Date of Injury: _____
3. _____ Date of Injury: _____

No symptoms/painful issues currently _____

Have you seen a general practitioner or specialist for any of these problems? **Y/N**
If Yes, Who? _____
Was there any treatment or diagnosis given? _____
Has the condition changed with treatment? **Y/N**
What activities make your pain worse/exacerbate symptoms? _____
What activities provide relief? _____
What medications are you currently taking? _____

_____

Do you take any vitamin or supplemental products? _____
Have you recently had any rapid weight gain or loss? _____
Marital Status: _____
Number of Children: _____ Age of children: _____
Handedness? **R/L**
General energy level (scale of 1-10, 10 being optimal): _____
Average hours of sleep per night: _____
Do you wake up feeling refreshed? **Y/N**
Do you have difficulty falling asleep? **Y/N**
Do you have insomnia? **Y/N**
Do you wake up at night to go to the bathroom? **Y/N** Number of times? _____
Can you fall back asleep easily? **Y/N** Depression? **Y/N**
Anxiety? **Y/N**
Do you feel extreme stress or pressure (general life, work) from day to day? **Y/N**

Do you smoke presently? **Y/N** Have you ever smoked? _____
How long have you smoked? _____
How much water do you drink per day? _____
Do you exercise regularly? **Y/N**
Types of exercise: _____

Have you been diagnosed with cancer? **Y/N**

Type? _____ When? _____

Treatments? _____

Please list **ALL** surgeries (including cosmetic) you have had including the dates _____

Are you currently pregnant? **Y/N** If yes, how many weeks? _____
Have you ever been hospitalized? **Y/N** How long? _____

Car Accidents? **Y/N** year _____ Sprains or Dislocations? **Y/N** where _____
Broken Bones? **Y/N** where _____ Any Large Scars? **Y/N**
Location of Scars _____
Sudden tiredness/weakness? **Y/N** Time of day? _____

Please check any areas that apply below:
Musculoskeletal System:

Low Back Pain _____ Broken Bones _____
Mid Back Pain _____ Leg Problems _____
Neck Pain _____ Torn Muscles _____
Arm Problems _____ Muscle Strains _____
Leg Problems _____ Ligament Sprains _____
Joint Pain or Dysfunction _____ Cartilage Dysfunction or Tears _____
Muscular Pain or Dysfunction _____ Constant Joint Stiffness or Ache _____
Arthritis _____ Hernia (type) _____
Difficulty Walking _____ MCT/Ehlers-Danlos Disease _____

Nervous system:

Numbness/Tingling _____ Frequent Headaches or Migraines _____
Parkinsons Disease _____ Chronic Fatigue Syndrome _____
Dizziness or Vertigo _____ Frequent Muscle Twitching/Spasms _____
MS _____ Lupus or Auto-Iimmune Condition _____
Fainting _____ Loss of Coordination _____
Fibromyalgia _____ Loss of Balance _____

Sinuses/Respiratory:

Nose Pain _____ Allergies _____
Frequent Nose Bleeds _____ Frequent Sinus Infections _____
Difficulty breathing through nose _____ Nose Surgery or Reconstruction _____
Hay Fever _____ Sinus Headaches _____

Please check any areas that apply below:

Mouth, Throat, Neck:

Frequent Sore Throats _____
Gum Problems _____
Grinding of Teeth, TMJ, Clicking Jaw _____
Dental Crowns, Bridges, Mouth Work _____
Gland Swelling _____
Braces (current or history) _____

Respiratory System:

Asthma _____
Chronic/Frequent Coughing _____
Pain on Breathing _____
Frequent Shortness of Breath _____

Cardiovascular System:

High Blood Pressure _____
Low Blood Pressure _____
Heart Murmurs _____
Heart Palpitations _____
Irregular Heart Beat _____
Varicose Veins _____

Gastrointestinal System:

Frequent Constipation _____
Frequent Diarrhea _____
Abdominal Pain _____
Colitis, Crohn's Disease, or Ulcers _____
Frequent Nausea/Vomiting _____
Frequent Heartburn _____
Frequent Indigestion or Gas _____
Frequent Cramps _____

Reproductive System:

Prostate Issues or Enlargements _____
Fibroids, Cysts, or Endometriosis _____
Frequent Cramping _____
Heavy Flow during Period _____
Menopause _____
Perimenopausal Symptoms _____
Hysterectomy _____
C-Section _____
Prolapse _____
Irregular Cycle _____
Rectocyle _____
Cytocele _____

Please list any other conditions or concerns you might have that might affect your massage or movement session

_____

_____

_____

If necessary, I allow my practitioners at **Full Circle Fitness** to discuss the appropriateness of massage and/or movement training for my general health and wellness with my healthcare providers and I understand that massage and/or movement training is not a replacement for medical treatment or medical diagnosis. I have filled out this medical history as accurately as possible and will update **Full Circle Fitness** immediately if there are any new conditions that arise.

Signature _____ Date _____