PURA VIDA HEALTHCARE
Your Mind-Body Connection

Confidential Health Questionnaire

Name: _____Date of Initial Visit: _____

Cell Phone: _____ Date of Birth: _____/_____/_____

Occupation: _____

Have you ever had massage/bodywork before? Yes_____ No_____

Referred by: _____

REASON FOR VISIT:

What is your primary concern? _____

What are other areas of concern? _____

When did you first notice it? _____ What brought it on? _____

Describe any stressors occurring at the time? _____

What provides relief? _____What makes it worse? _____

Is this condition getting worse? _____ Interfere with work? _____ Sleep? _____

Recreation? _____ Describe your exercise routine (type, frequency):_____

_____

EMOTIONAL & SPIRITUAL:

On a scale of 1- 10 (1 being the lesser, 10 the greater), please rate yourself on the below:

Fear/Anxiety: _____ Grief: _____Anger: _____ Guilt: _____

Worry: _____ Other (describe briefly): _____

970.426.1684 (office) 1.970.797.1544 (fax) www.puravidahealthcare.com
160 E. 12th Street, Suite 1, Durango, CO 81301

What are your hobbies/activities that provide you with a sense of pleasure and accomplishment?

_____

MEDICAL HISTORY:

Are you currently under care of another health care provider(s)? Yes No

Reason(s): _____

Name(s) of Practitioner: _____Phone: _____

Current Medications: _____

Allergies (specify allergen and reaction): _____

Supplements/Remedies: _____

_____

Recent Procedures: _____

Accidents or Traumas: _____

Falls/Injuries to sacrum/head/tailbone (describe) _____

CIRCLE any of the following you are CURRENTLY experiencing UNDERLINE any of the following you have experienced in the PAST:

Headaches (migraine, tension, cluster) Ringing in the Ears Sinus Condition Asthma

Pins and needles in arms, hands and/or feet Numb legs and feet when standing still

Swollen ankles Swollen Joints Painful Joints Seizures

Skin Disorders: Acne, Fungus, Psoriasis, Other:_____

Spinal Problems Trouble Sleeping Fainting Spells Loss of Memory

Muscular Tightness (location):_____Varicose Veins (location): _____

Herniated or Bulging disc (location): _____ Contact Lenses_____

Dentures_____ Artificial/Missing Limbs Frequent Colds/Upper Respiratory conditions

ADDITIONAL COMMENTS:

_____

_____