Massage Therapy

GENERAL INFORMATION

Date:_____ How did you hear of us? _____

Would you like an email confirmation for your scheduled appointment instead of a phone call? **Yes / No**

Name: Last:_____ First:_____ M.I.:_____

Address: _____ City: _____ State: _____Zip:_____

Date of Birth:____/_____/_____ Occupation :_____

Phone: Home:_____ Work:_____

Other:_____ E-Mail:_____@_____-_____

Emergency Contact Name:_____ Phone:_____

MEDICAL HISTORY

General Health (check one): ___Excellent ___Good ___Fair ___Poor

Have you had any medical problems or hospitalizing in the past year (circle)? Yes No
If "yes", please specify: 1.
2.
3.

Surgical History: Procedure:_____ Date:_____
Procedure:_____ Date:_____

Prescriptions Medications: _____
Over-the-counter Medications: _____
Tobacco Yes No If yes, please specify years: _____
Alcohol (circle): Yes No If yes, please specify: amount/day, week, or month: _____
Caffeine Yes No # drinks/day _____
During the past month have you felt down, depressed, or hopeless? Yes No
During the past month, have you lost interest or pleasure in doing things? Yes No
Is this something with which you would like help? Yes No Yes, but not today

Past Injury/Problem History

Date	Injury/Problem	Whom Seen	Treatment	Recovery Time
1.				
2.				
3.				

Present Injuries/Problems (if applicable):

Date of Injury/Onset: _____ Body Part(s):

Mechanism of Injury/Onset: _____

Type of Onset (check one): ____Gradual ____Sudden

Symptoms at the time of onset: _____

Current symptoms (aggravate/relieve):_____

Present/past medical conditions (circle):

Asthma	Y	N	Heart Attack	Y	N
Arthritis	Y	N	Heart Disease	Y	N
Cancer	Y	N	Hernia	Y	N
Chemical Dependency	Y	N	High Blood Pressure	Y	N
Circulatory Disease	Y	N	Kidney Disease	Y	N
Depression	Y	N	Metal/other implant	Y	N
Diabetes	Y	N	Multiple sclerosis	Y	N
Dizziness	Y	N	Nervous Disorder	Y	N
Eating Disorder	Y	N	Numbness	Y	N
Emphysema	Y	N	Osteoporosis	Y	N
Epilepsy	Y	N	Pregnancy	Y	N
Fainting	Y	N	Stroke	Y	N
Fatigue	Y	N	Thyroid Problems	Y	N
Headaches	Y	N	Tuberculosis	Y	N
Hepatitis	Y	N	Weakness	Y	N
Fever/chills/sweats	Y	N	Bowel dysfunction	Y	N
Unexplained weight change	Y	N	Urinary frequency changes	Y	N
Nausea/vomiting	Y	N	Incontinence	Y	N
Night pain	Y	N	Sexual dysfunction	Y	N
Dyspnea	Y	N	Pain with sexual intercourse	Y	N
Blood Clot (DVT)	Y	N	Constipation	Y	N

Comments:

Has any one in your immediate family been treated for any of the conditions listed on the previous page? If yes, please specify:

_____

What are your reasons for coming today? _____

What are your goals for getting massage? _____

Short Term _____ Long Term_____

Have you ever had professional bodywork? If yes please specify _____

On a scale of 1-10 (1 being lowest 10 being highest), How willing are you to participate in your healthcare goals?

1_____I_____I_____I_____5_____I_____I_____I_____I_____10

How do you view the massage modality as fitting in to your health care goals? Circle One:

1. Extremely necessary
2. Very helpful
3. Only because I was referred
4. Not at all

Current recreational/fun activities

1._____
2._____
3._____

Do you feel your posture is (please circle one): Good Fair Needs Improvement

If needs improvement: what and why? _____

Where is your pain?

Please mark on the drawings below the areas where you feel your pain.