All information is held in strictest confidence. You may choose to skip answering any question you feel impinges on personal information you do not wish to disclose.

Name:_____ Date:_____

Date of Injury:_____ Referred by:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Telephone #:(_____)_____ Cellular #:(_____) _____

Email Address:_____

Date of Birth:_____

Occupation:_____

Employer:_____ Telephone: (_____)_____

Primary Physician:_____ Telephone : (_____)_____

Emergency Contact:_____ Phone:_____

Allergies:_____

Surgeries:_____

Medications:_____

History of Pathology

1. List areas of discomfort or pain_____
2. Describe onset of discomfort or pain_____

_____

3. Rate of pain today - please circle 1 2 3 4 5 6 7 8 9 10
   Very little very painful
4. Frequency - please circle Constant Off/On At Rest With Activity
5. At what time of day is the pain at it's worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ During Sleep
6. Have you ever injured this area before? ☐ No ☐ Yes, PLEASE EXPLAIN AND INCLUDE DATES_____

_____

Continued on next page

7. Have you ever been in an accident (automobile, work related, falls, etc.)? ☐ No ☐ Yes, PLEASE EXPLAIN & INCLUDE DATES

_____

_____

_____

_____

_____

8. List all related treatments received for this injury:_____

_____

_____

9. Have you ever received a therapeutic massage for a specific problem or injury? ☐ Yes ☐ No

If yes, date of last massage_____

Was the treatment used effective_____

10. Is there anything that you do that creates, increases or decreases pain? ☐ No ☐ Yes, PLEASE EXPLAIN AND INCLUDE DATES

_____

_____

11. What are the physical duties required of your occupation?_____

12. What activities / hobbies do you enjoy?_____

13. List exercise and stress reduction activities: Include frequency_____

_____

14. In what position do you most often wake up? ☐ Back ☐ Side ☐ Stomach

15. Are you currently seeing any other healthcare professional? ☐ No ☐ Yes, if yes please list_____

_____

Please check any of the symptoms that apply to you and circle right or left when applicable:

HEAD:
- ☐ Neck
  - ☐ temples
  - ☐ forehead
  - ☐ top of head
  - ☐ in the eyes
  - ☐ entire head
  - ☐ base of skull
- ☐ Dizziness
- ☐ Fainting
- ☐ Light-headness
- ☐ Pain in ears
- ☐ Ringing in ears

NECK:
- ☐ Stiffness
- ☐ Pain at neck shoulder junction
- ☐ Pain when turning head
- ☐ Pain with side to side head movements
- ☐ Neck feels out of place
- ☐ Muscle spasm in neck
- ☐ Gliding/Grating sound with neck movement
- ☐ Diagnosed arthritic neck
- ☐ **Diagnosed disc herniation What level?_____**
- ☐ **Diagnosed bone spurs**

LOW BACK:
- ☐ Low back pain
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
- ☐ Pinched nerve in low back
- ☐ Low back feels out of place
- ☐ Diagnosed arthritis
- ☐ Diagnosed disc herniation what level?_____
- ☐ Pain up/down low back
- ☐ Pain across low back

MID BACK:
- ☐ Mid-back pain
- ☐ Pain between shoulder baldes
- ☐ Pain up/down back
- ☐ Pain across mid back
- ☐ Pain with breathing

ABDOMEN:
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diagnosed irritable bowel/colitis

SHOULDERS:
- ☐ Pain in shoulder
  - ☐ Front
  - ☐ Back
  - ☐ Side
- ☐ Pain deep in shoulder joint
- ☐ Diagnosed bursitis
- ☐ Diagnosed Arthritis
- ☐ Can't raise arm
  - ☐ Above shoulder level
  - ☐ Over head

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in wrist
- ☐ Pain in fingers
- ☐ Sensation of pins and needles in arm
- ☐ Sensation of pins and needles in fingers
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Diagnosed arthritis
- ☐ Loss of grip strength

HIPS:
- ☐ Pain in buttocks
  - ☐ Standing
  - ☐ Sitting
- ☐ Pain on side of hip
- ☐ Pain deep in hip joint
- ☐ Pain on sit bone
- ☐ Diagnosed bursitis
- ☐ Diagnosed arthritis

LEGS AND FEET
- ☐ Pain down leg (R - L)
- ☐ Pain down both legs
- ☐ Leg cramps
- ☐ Pin & needles in legs (R-L)
- ☐ Numbness in leg (R - L)
- ☐ Numbness in feet (R - L)
- ☐ Numbness in toes
- ☐ Feet feel cold
- ☐ Cramps in feet (R - L)
- ☐ Swollen ankles (R - L)
- ☐ Swollen feet (R - L)
- ☐ Pain in foot (R - L)
- ☐ Pain in knee (R - L)
- ☐ Diagnosed arthritis

GENERAL
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel rundown
- ☐ Loss of sleep
- ☐ Loss of weight

Family History

✓ Check items that are known conditions **you** have

X Items that are known conditions among **family** members, and fill in relationship to you.

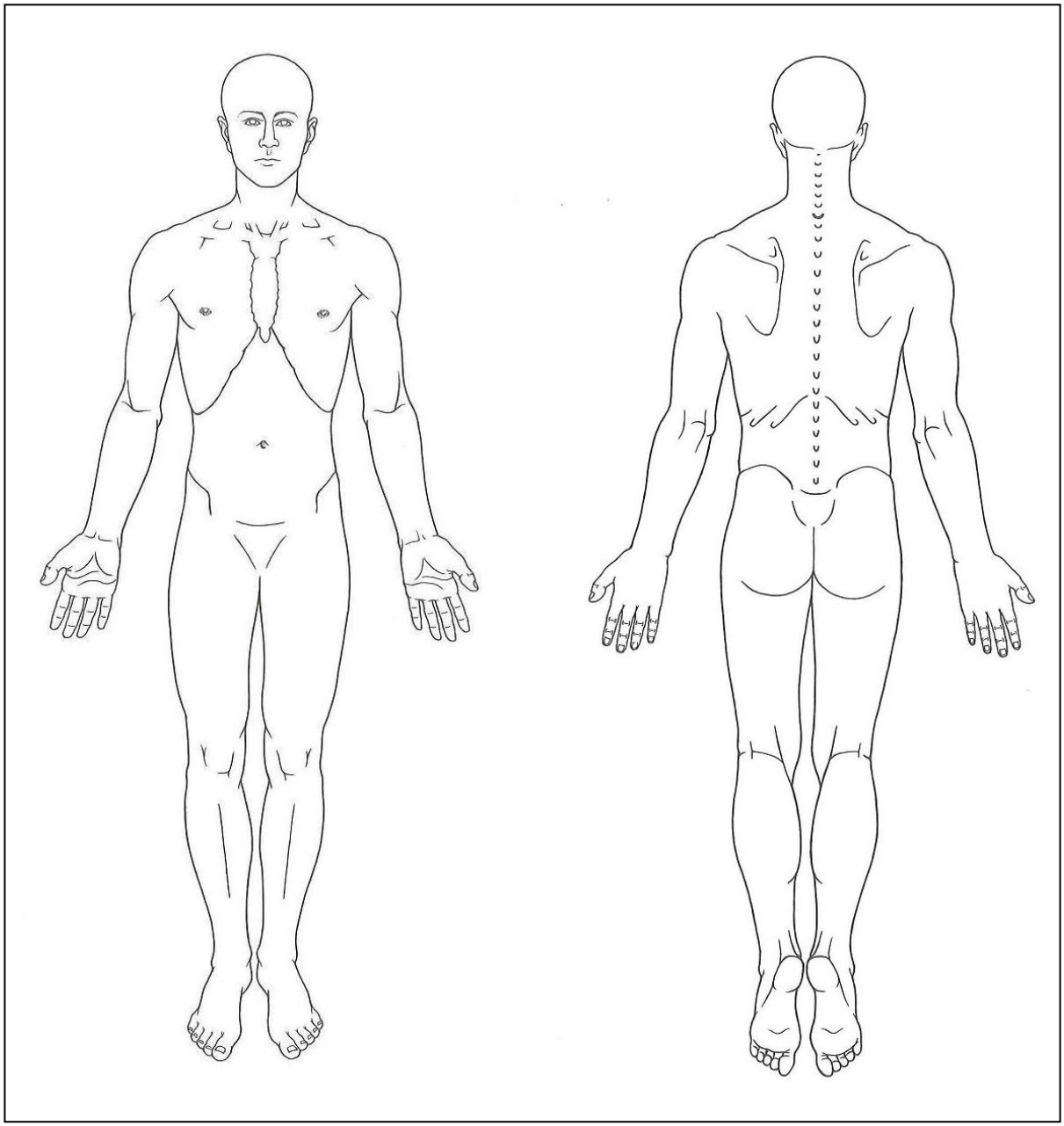
- ☐ Kidney
  Relation to You
  _____
- ☐ Anemia
  Relation to You
  _____
- ☐ Appendicitis
  Relation to You
  _____
- ☐ Cancer
  Relation to You
  _____
- ☐ Diabetes
  Relation to You
  _____
- ☐ Emphysema
  Relation to You
  _____
- ☐ Heart Disease
  Relation to You
  _____
- ☐ Miscarrige
  Relation to You
  _____
- ☐ Multiple Sclerosis
  Relation to You
  _____
- ☐ Stroke
  Relation to You
  _____
- ☐ Ulcer
  Relation to You
  _____
- ☐ Foot Problems
  Relation to You
  _____

Do you participate in any of the following:

	Never	Sometimes	Always
Alcohol	☐	☐	☐
Coffee	☐	☐	☐
Tobacco	☐	☐	☐

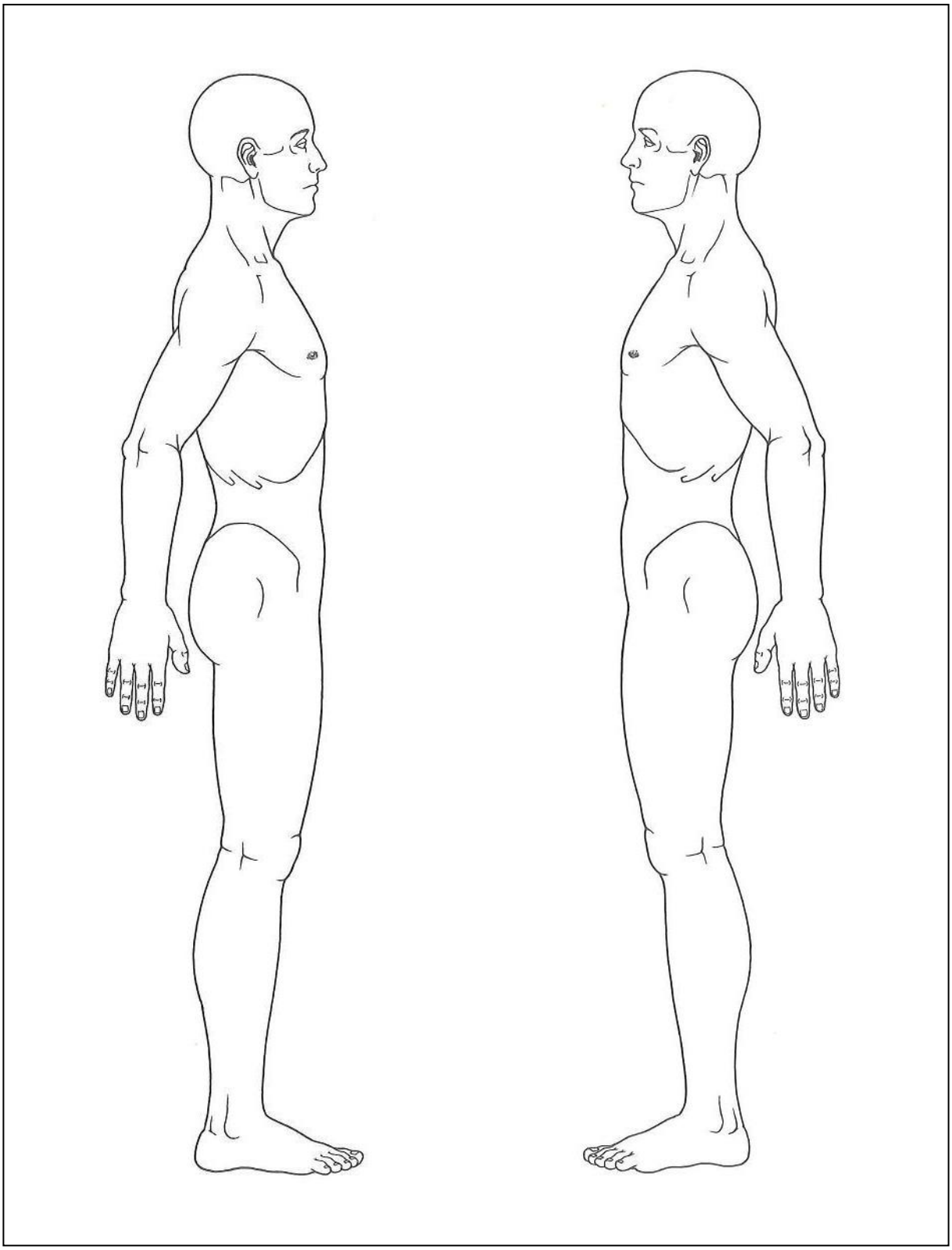
Front/Back of Body

Please place an “X” on any area of pain or discomfort



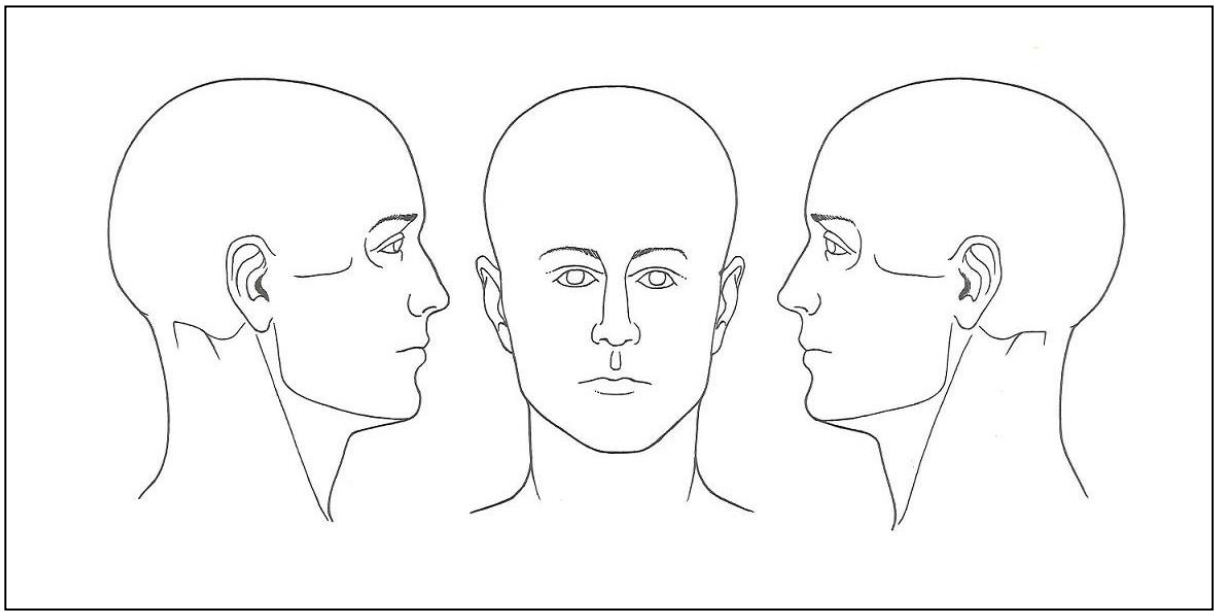
Right/Left of Body

Please place an “X” on any area of pain or discomfort



Head/Neck

Please place an “X” on any area of pain or discomfort



Consent:

I understand that therapeutic massage therapists do not diagnose illness, disease, any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform joint mobilization.

I acknowledge that massage therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for that service.

It is my choice to receive therapeutic massage as a form of therapy.

I understand that treatment given is designed to address the care and prevention of myofascial pain and dysfunction.

I have stated my pertinent medical conditions, and will update the massage therapist of any changes in my health status.

Permission to consult with your physician? ☐ Yes ☐ No

Signature: _____

Date: _____ Print Name: _____