Manual Therapist

HEALTH INFORMATION

Patient Name ______________________ Date __________

Age:__________ Male or Female (circle one)

A. Patient Information

Address ______________________

City __________ State ____ Zip ______

Phone: Home ______________________

Work __________ Cell __________

Employer ______________________

Work Address ______________________

Occupation ______________________

Emergency Contact ______________________

Phone: Home ______________________

Work __________ Cell __________

B. Current Health Information

List Health Concerns Check all that apply

Primary ______________________

☐ mild ☐ moderate ☐ disabling

☐ constant ☐ intermittant

☐ symptoms ↑ w/activity ☐ ↓ w/activity

☐ getting worse ☐ getting better ☐ no change

treatment received ______________________

Secondary ______________________

☐ mild ☐ moderate ☐ disabling

☐ constant ☐ intermittant

☐ symptoms ↑ w/activity ☐ ↓ w/activity

☐ getting worse ☐ getting better ☐ no change

treatment received ______________________

Additional ______________________

☐ mild ☐ moderate ☐ disabling

☐ constant ☐ intermittant

☐ symptoms ↑ w/activity ☐ ↓ w/activity

☐ getting worse ☐ getting better ☐ no change

treatment received ______________________

List Daily Activities Limited by Condition

Work ______________________

Home/Family ______________________

Sleep/Self-care ______________________

Social/Recreational ______________________

List Self-Care Routines

How do you reduce stress? ______________________

Pain? ______________________

List current medications (include pain relievers and herbal remedies) ______________________

Have you ever received massage therapy before? ______ Frequency? __________

What are your goals for receiving massage therapy? ______________________

C. Health History

List and Explain. Include dates and treatment received.

Surgeries ______________________

Injuries ______________________

Major Illnesses ______________________

HEALTH INFORMATION

Check All Current and Previous Conditions Please Explain

General

current | past | comments

- ☐ ☐ headaches ____________
- ☐ ☐ pain ____________
- ☐ ☐ sleep disturbances ____________
- ☐ ☐ fatigue ____________
- ☐ ☐ infections ____________
- ☐ ☐ fever ____________
- ☐ ☐ sinus ____________
- ☐ ☐ other ____________

Skin Conditions

current | past | comments

- ☐ ☐ rashes ____________
- ☐ ☐ athlete's foot, warts ____________
- ☐ ☐ other ____________

Muscles and Joints

current | past | comments

- ☐ ☐ rheumatoid arthritis ____________
- ☐ ☐ osteoarthritis ____________
- ☐ ☐ osteoporosis ____________
- ☐ ☐ scoliosis ____________
- ☐ ☐ broken bones ____________
- ☐ ☐ spinal problems ____________
- ☐ ☐ disk problems ____________
- ☐ ☐ lupus ____________
- ☐ ☐ TMJ, jaw pain ____________
- ☐ ☐ spasms, cramps ____________
- ☐ ☐ sprains, strains ____________
- ☐ ☐ tendonitis, bursitis ____________
- ☐ ☐ stiff or painful joints ____________
- ☐ ☐ weak or sore muscles ____________
- ☐ ☐ neck, shoulder, arm pain ____________
- ☐ ☐ low back, hip, leg pain ____________
- ☐ ☐ other ____________

Nervous System

current | past | comments

- ☐ ☐ head injuries, concussions ____________
- ☐ ☐ dizziness, ringing in ears ____________
- ☐ ☐ loss of memory, confusion ____________
- ☐ ☐ numbness, tingling ____________
- ☐ ☐ sciatica, shooting pain ____________
- ☐ ☐ chronic pain ____________
- ☐ ☐ depression ____________
- ☐ ☐ other ____________

Respiratory, Cardiovascular

current | past | comments

- ☐ ☐ heart disease ____________
- ☐ ☐ blood clots ____________
- ☐ ☐ stroke ____________
- ☐ ☐ lymphadema ____________
- ☐ ☐ high, low blood pressure ____________
- ☐ ☐ irregular heart beat ____________
- ☐ ☐ poor circulation ____________
- ☐ ☐ swollen ankles ____________
- ☐ ☐ varicose veins ____________
- ☐ ☐ chest pain, shortness of breath ____________
- ☐ ☐ asthma ____________

Allergies

current | past | comments

- ☐ ☐ scents, oils, lotions ____________
- ☐ ☐ detergents ____________
- ☐ ☐ other ____________

Digestive/Elimination System

current | past | comments

- ☐ ☐ bowel problems ____________
- ☐ ☐ gas, bloating ____________
- ☐ ☐ bladder/kidney/prostrate ____________
- ☐ ☐ abdominal pain ____________
- ☐ ☐ other ____________

Endocrine System

current | past | comments

- ☐ ☐ thyroid ____________
- ☐ ☐ diabetes ____________

Reproductive System

current | past | comments

- ☐ ☐ pregnancy ____________
- ☐ ☐ painful, emotional menses ____________
- ☐ ☐ fibrotic cysts ____________

Cancer/Tumors

current | past | comments

- ☐ ☐ benign ____________
- ☐ ☐ malignant ____________

Habits

current | past | comments

- ☐ ☐ tobacco ____________
- ☐ ☐ alcohol ____________
- ☐ ☐ drugs ____________
- ☐ ☐ coffee, soda ____________

I, ______________________, understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow. I understand that massage therapists do not diagnose illnesses, disease or any other physical or mental disorder. As such, the massage therapist(s) do not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis, and that it is recommended that I see a physician for any physical ailment that I may have. Because the massage therapist must be aware of existing physical conditions, I have stated all of my known medical conditions and take it upon myself to keep the massage therapist(s) updated on my physical health.

Signature ______________________ Date ____________

Therapist ______________________ Date ____________