Therapeutic Medical Massage Intake form

General Information please circle and fill in all applicable items

Name: First_____ Last: _____ Age: _____ DOB: ___/___/____ M F

Address: _____ City: _____State: _____ Zip: _____

Home Phone: ____/_____/_____ work or cell phone: _____/_____/_____

Found out about us: web, friend, referred by: _____ Email: _____

Occupation: _____Employer: _____

Emergency Contact: _____ Phone: _____

Do you? Smoke Y N ___ per day Drink Alcohol Y N _____ per day Exercise _____ x per week

Current Complaints

1._____ How long _____ Getting: Worse Better Prior History Yes No

2._____ How long _____ Getting: Worse Better Prior History Yes No

3._____ How long _____ Getting: Worse Better Prior History Yes No

Are your current complaints due to an injury? Yes No Auto Work Sports Other _____

Has an accident been reported? Y N Have you retained an attorney? Y N Name: _____

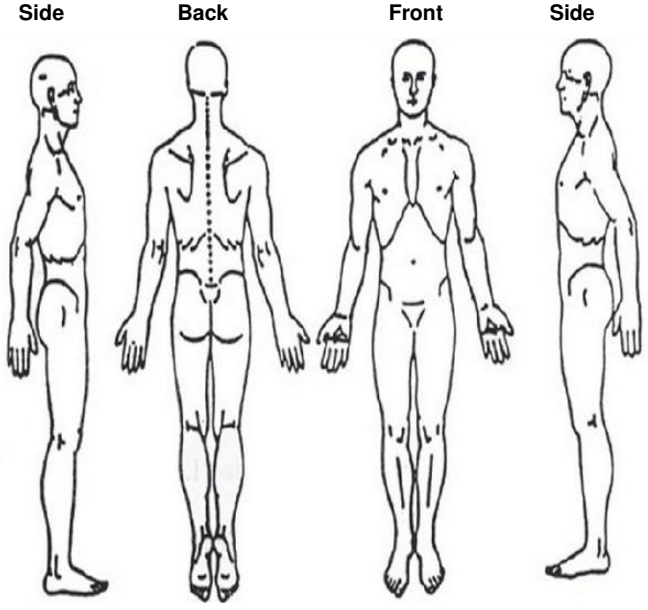
Prior Treatment

Have you been treated for the above complaints by a Chiropractor Physical Therapist Naturopath Osteopath MD

Acupuncturist? Name of the provider: _____ When? _____

Results of the treatment: _____

Have you received massage therapy? Y N Name: _____ When: _____



Subjective Status Pain Scale

less 0 1 2 3 4 5 6 7 8

9 10 more

Please circle your pain level and indicate the areas of discomfort on the picture .

P-Pain A- Ache Sp- Spasm

T- Tingling B- Burning S-Stiff

Sh- Shooting N- Numbness

Client History

Circle all current conditions- AND- all recurrent conditions- AND – all previously diagnosed conditions rendered from a health care provider.

Allergies _____ Shoulder Pain____ Asthma ___ Spitting Blood _____ Weight gain ____ Fever _____

Chills _____ Elbow/Wrist Pain____ Emphysema____ Blood in Urine/stool ____ Diarrhea ___ Herniated Discs (where?) _____

Convulsions___ Ear noises _____ Deafness ____ Head Injury_____ Ear Pain _____ Lumbar spinal stenosis, spondylitis___

Dizziness/Fainting ___ Swollen Joints ___ Knee/Foot pain ____ Frequent Urination_____ Breast Implants ____ Pacemaker_____

Joint Surgery _____Belching/gas _____ Thyroid disease_____ Diff. holding urine _____ Nervousness_____ Hemorrhoids_____

Fatigue _____ Indigestion ____ Hoarseness _____ Painful urination _____ Excess hunger ____ Fibromyalgia _____

Headache _____ Acid Reflux _____ Bleeding _____ Prostate disease _____ Chest Pain _____ Broken/Cracked ribs_____

Loss of sleep ___ Irritable Bowel___ Painful periods ____ Jaundice _____ Pregnancy _____ Varicose Veins _____

Nerve Pain ____ Easy Bruising _____ High blood pressure __ Low blood pressure____ Seizures ____ Blood Clots_____

Night sweats _____ Hepatitis _____ Depression _____ Liver disease _____ Gall Blad. disease ___ TMJ dysfunction___

Numbness _____Anxiety _____ Heart pain _____ Recur. Twitches _____ Heart disease _____ Sprains/Strains _____

Tremors _____ Aids _____ Strokes _____ Cancer _____ Difficulty Breathing ____ Osteoporosis _____

Diabetes _____ Pancreatic disease _____ Neck Pain _____ Ankle /Feet Swelling ___ Neck/Back Injuries ___ Skin allergies_____

Kidney disease/Dialysis ___ Arthritis/Tendonitis_____ Lupus _____ Thoracic Pain _____ Nausea _____

Varicose Veins _____ Multiple Sclerosis _____ Low Back pain _____ Abdominal Pain _____ Boils, Skin Lesions _____

Other Health Information

Surgeries: **Initial here:** ☐ If you have NEVER had any surgeries.

List all Surgeries	**Dates**	**List all Surgeries**	**Dates**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Injuries: **Initial here:** ☐ If you have NEVER had any injuries.

List all accidents resulting in treatable injuries. Include auto and spinal injuries. **List all Dates**

_____ _____

_____ _____

Spinal History: **Initial here:** ☐ If you have NEVER had any non-surgical spinal procedures.

List all non -surgical procedures including spinal taps, injections, braces etc. **List all Dates**

_____ _____

List all Medications, Nutritionals, Herbs and Supplements **Are you currently taking any Pain Killers(which?)** _____

_____

Statement of Accuracy and Consent to Treat: By signing below, I understand that massage therapy is not a substitute for medical diagnosis and it is recommended that I work concurrently with my primary care physician for any condition that I may have. I agree that I have completed the above form and I have not omitted nor misrepresented any requested health information and that with all healthcare protocols, there is an inherent risk of post treatment soreness and/or aggravation of known and unknown pre-existing conditions. I further understand that the inherent risks noted above are substantially less than the adverse effects of NSAIDS and various other medications for the control of muscular skeletal dysfunction. I fully understand the above and give my full consent for assessment and treatment according to the standards and practice of soft tissue therapy.

Signature of Client or Guardian: _____ **Date**: _____/ _____/_____