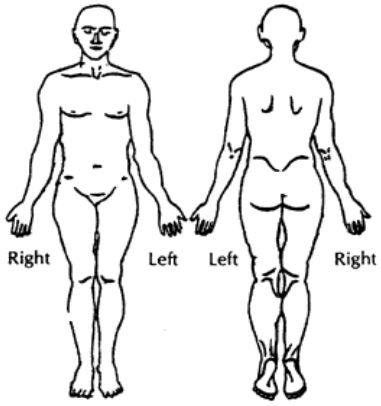
MASSAGE THERAPY INTAKE FORM

NAME: _____ DATE OF BIRTH: _____ DATE: _____

1. What problem are you here for today? _____
2. Describe how/when your problem occurred? _____
3. Please **circle** on the body chart below your area of discomfort:



   a. Mark on the scale below your current level of discomfort (0=no pain, 10=visit to ER):

      0----------5----------10

   b. **Check** the box that best describes how your discomfort changes during the day:

	Morning	Afternoon	Evening
Better			
Worse			

4. Does your pain wake you up at night? **YES** **NO**
5. Please **circle** the activity/activities that increase your symptoms:

Sitting	Walking	Kneeling	Twisting	Standing	Reaching
Reclining	Lifting	Bending	Squatting	Stairs	Rising from Chair
Other:					

6. Please **circle** the intervention(s) that ease(s) your symptoms:

Heat	Ice	Medication	Rest	Change in Position
Other:				

7. Is your condition overall…? **IMPROVING** **GETTING WORSE** **THE SAME**
8. Have you had a similar problem previously? **YES** **NO**
   a. If yes, when? _____
9. Have you had any treatment for this problem in the past? **YES** **NO**
   a. If yes, please describe: _____

10. Are you able to continue working? **YES** **NO**
    a. If no, when did you last work?_____

11. Are the physical demands of your job…? **LIGHT** **MODERATE** **HEAVY**
    a. Please describe your job duties:_____

12. Are you able to continue your recreation or sporting activities?
    a. Please list your hobbies and activities:_____

What are your goals and expectations for massage therapy?_____

MEDICAL INFORMATION

1. Please **circle** if you have had any of the following tests for this problem:

X-Ray	CAT Scan	Bone Scane	Electromyelogram	Nerve Conduction Study	MRI
Other:					

2. Are you currently taking any medications? **YES** **NO**
    a. Name/Dosage/Reasons for medication:_____
    _____

3. Please **circle** if you have experienced any of the following with your current problem:

Locking	Dislocating	Giving Way	Dropping Items	Unconsciousness	Numbness Around Groin or Buttocks
Nausea	Loss of Balance	Lip Numbness	Loss of Bowel or Bladder Control	Dizziness or Blurred Vision	Pain with Coughing/Sneezing

4. How would you describe your overall health? **POOR** **FAIR** **GOOD** **EXCELLENT**

5. Please **circle** any of the following that are in your past or present medical history:

Surgeries	Cancer	Lung Problems	Heart Disorder	Pacemaker	Nerve Disorder
Diabetes	Asthma	Allergies	High Blood Pressure	Blood Clots	Osteoporosis
Arthritis	Sprains/Strains	Broken Bones	Unusual or Frequent Headache	Seizures	Concussion
Other:					

6. Have you had any long-term use of Prednisone, Cortisone, steroid, or inhalants? **YES** **NO**
    a. If yes, please specify: _____

7. Are you currently doing physical therapy, or plan to, for this issue? **YES** **NO** **UNSURE**

8. Are you pregnant, or do you think you might be? **YES** **NO** **UNSURE**