MASSAGE THERAPY CONFIDENTIAL PATIENT HEALTH RECORD

Name_____ Email_____

Address_____ Birth Date_____

City_____ Physician_____

Postal Code_____ Chiropractor_____

Ph. Home_____ Physiotherapist_____

Ph. Work / Cell_____ Referred by_____

Occupation_____ Or Google ☐

1. **Do you or your spouse have any private insurance that covers massage?** If Yes:
   Company_____ Group & Policy Number_____

2. **Have you had previous massage therapy care?** If Yes:
   Who_____ Where_____ When_____
   Results: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

3. **Are you presently taking prescription medication or over the counter medications?**
   If yes, specify_____
   _____
   _____

4. **Are you presently in treatment with other Health Care Practitioners (DC PT, etc.)?** If yes, specify_____
   _____
   Results: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

5. **Is your injury work related?** If Yes, specify_____
   _____
   _____

6. **Is your injury due to a motor vehicle accident?** If Yes, specify_____
   _____
   _____

7. **Have you had any illness within the last 3 weeks (colds, influenza, bladder/kidney infection, etc.)?** If yes, specify_____
   _____

8. **Do you have any sores/wounds that have not healed, or changes in the size/shape/color of a wart/mole?** If yes, specify_____
   _____

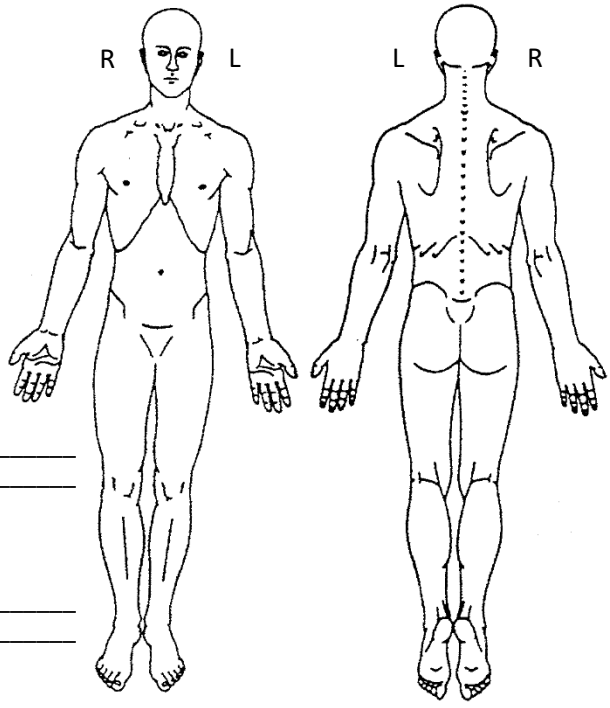
9. **Do you have a pacemaker, transplant organ, or metal implants?** If yes, specify_____
   _____
   _____

PATIENT PAIN RECORD

Directions: There are many words that describe pain. Some of these words are grouped below. **Check (✓) one word per category that best describes your pain.** Any category that does not describe your pain should remain blank.

1.	☐ Pulse	☐ Throbbing	☐ Beating	☐ Pounding	
2.	☐ Boring	☐ Drilling	☐ Stabbing		
3.	☐ Pinching	☐ Pressing	☐ Cramping		
4.	☐ Hot	☐ Burning	☐ Cool	☐ Cold	
5.	☐ Dull	☐ Sore	☐ Aching	☐ Heavy	
6.	☐ Spreading	☐ Radiating	☐ Penetrating	☐ Piercing	
7.	☐ Annoying	☐ Troublesome	☐ Miserable	☐ Unbearable	
8.	☐ Tiring	☐ Punishing	☐ Cruel	☐ Killing	☐ Terrifying ☐ Frightful
9.	☐ Tight	☐ Numb			
10.	☐ Jumping	☐ Shooting			
11.	☐ Sharp	☐ Cutting			
12.	☐ Tugging	☐ Pulling			
13.	☐ Tingling	☐ Itchy			
14.	☐ Tender	☐ Taunt			

Mark the areas on the diagram where you feel the described sensations.



1. **What is your reason for consulting a Massage Therapist?**_____
   _____
   _____

2. **When did your pain/symptoms originally start?**
   _____
   _____

3. **How did your pain/symptoms start?** Describe:
   ☐ Gradually ☐ Suddenly ☐ On & Off
   _____
   _____

4. **What time of day is your pain/symptoms worse?**
   ☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight

5. **What movements can't you do because of your pain/symptoms?**
   _____
   _____

6. **What treatments have made your pain/symptoms better or worse?**
   _____
   _____

7. **Rate your sleep (hours per night):** ☐ 4-6 ☐ 6-8 ☐ 8-10
   Do you wake up feeling rested? ☐ Yes ☐ No

8. **Do you have any allergies?** *Are you allergic to latex gloves or nuts?* If yes, specify:
   _____

9. **Do you exercise?** ☐ Yes ☐ No
   Do you take vitamins or herbs? If yes, specify:_____
   _____