Patient Name: _____ Date: _____
Date of Injury: _____ ID#/DOB: _____

**A. Patient Information**

Address: _____ City: _____
State: _____ Zip: _____
Phone(Home): _____ Work: _____
Cell: _____ Employer: _____
Work Occupation: _____
Address: _____
Emergency Phone(Home): _____
Contact: _____
Cell: _____ Work: _____

**Primary Health Care Provider**

Name: _____ Address: _____
City: _____ State/Zip: _____
Phone: _____ Fax: _____

I give my massage therapist permission to consult with my health care providers regarding my health and treatment.
Comments: _____ Initials: _____ Date: _____

**B. Current Health Information**

| List Health Concerns Check all that Apply Primary _____ | List Health Concerns Check all that Apply Secondary _____ | List Health Concerns Check all that Apply Additional _____ |
|---|---|---|
| ☐ mild | ☐ mild | ☐ mild |
| ☐ moderate | ☐ moderate | ☐ moderate |
| ☐ disabling | ☐ disabling | ☐ disabling |
| ☐ constant | ☐ constant | ☐ constant |
| ☐ intermittent | ☐ intermittent | ☐ intermittent |
| ☐ symptoms increase w/ activity | ☐ symptoms increase w/ activity | ☐ symptoms increase w/ activity |
| ☐ symptoms decrease w/ activity | ☐ symptoms decrease w/ activity | ☐ symptoms decrease w/ activity |
| ☐ getting worse | ☐ getting worse | ☐ getting worse |
| ☐ getting better | ☐ getting better | ☐ getting better |
| ☐ no change | ☐ no change | ☐ no change |
| Treatment Received | Treatment Received | Treatment Received |
| _____ | _____ | _____ |

**List Daily Activities Limited by Condition**

Work: _____ Sleep/Self-care: _____

Home/Family: _____ Social/Recreational: _____

**List Self-Care Routines**

How do you reduce stress? _____ List Current Medications: _____

Pain? _____ What are your goals for receiving Massage Therapy? _____

Have you ever received Massage Therapy before? _____ Frequency? _____

**C. Health History**

Surgeries: _____ Injuries: _____ Major Illnesses: _____

**Check All Current and Previous Conditions** Please Explain

**General**

| | Current | Past | Comments |
|---|---|---|---|
| Headache | ☐ | ☐ | _____ |
| Pain | ☐ | ☐ | _____ |
| Sleep Disturbances | ☐ | ☐ | _____ |
| Fatigue | ☐ | ☐ | _____ |
| Infections | ☐ | ☐ | _____ |
| Fever | ☐ | ☐ | _____ |
| Sinus | ☐ | ☐ | _____ |
| Other | ☐ | ☐ | _____ |

**Skin Conditions**

| | Current | Past | Comments |
|---|---|---|---|
| Rashes | ☐ | ☐ | _____ |
| Athlete's Foot/Warts | ☐ | ☐ | _____ |
| Other | ☐ | ☐ | _____ |

**Allergies**

| | Current | Past | Comments |
|---|---|---|---|
| Scents/Oils/ Lotions | ☐ | ☐ | _____ |
| Detergents | ☐ | ☐ | _____ |
| Other | ☐ | ☐ | _____ |