Manual Therapist

HEALTH INFORMATION

Name _____ Date _____

Email _____ Phone _____

A. Patient Information

Address _____

City _____ State ____ Zip _____

Phone: Home _____

Work _____ Cell _____

Employer _____

Work Address _____

Occupation _____

Emergency Contact _____

Phone: Home _____

Work _____ Cell _____

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 _____

☐ 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 _____

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

Contract for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

Consent for Care

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature _____ Date _____