How did you find out about our clinic? Please mark with an "X" (all that apply)

☐ Physician	☐ WCB/Insurance	☐ Lawyer
☐ Prior Patient at clinic	☐ Community Newsletter	☐ Sporting event
☐ Word of Mouth, Name: _____	☐ Magazine ad	☐ Employer
☐ Running Room lecture	☐ Other health care provider	☐ Website
☐ Yellow pages	☐ Walk by/signage	☐ Trade Fair

MASSAGE THERAPY PATIENT MEDICAL HISTORY

PATIENT NAME: _____

MAIN CONCERN: _____

Onset: _____ Rate Symptoms (please circle one): 0 1 2 3 4 5 6 7 8 9 10

CURRENT MEDICATIONS: _____

HISTORY: (Include description and dates)

Surgeries: _____

Accidents: _____

Date of last Massage: _____

Please circle if currently a problem, <u>underline</u> if it was a past problem.

MUSCULOSKELETAL	CIRCULATORY	SKIN	DIGESTIVE	RESPIRATORY
Bone or joint disease	Heart condition	Dryness	Constipation	Chest pain
Tendonitis/Bursitis	Varicose veins	Bruise easily	Diarrhea	Chronic cough
Jaw pain/TMJ	Blood clots	Rashes	Gas/bloating	Asthma/Allergies
Broken/fractured bones	High/low blood pressure	Athletes foot	Irritable bowel syndrome	Difficulty breathing
Arthritis	Lymph edema	Warts		Ear aches
Sprains/Strains	**GENITO-URINARY**	**NERVOUS SYSTEM**	**INFECTIOUS OR COMMUNICABLE DISEASES**	
Low back/hip/leg pain	Pregnant	Numbness/tingling	Please list _____	
Neck/shoulder/arm pain	PMS	Chronic pain	_____	
Headaches/head injuries	Menopause	Herpes/shingles	_____	
Spasms	Frequent urination	Fatigue	_____	
Fibromyalgia	Kidney infection	Sleep disorder	_____	
Flat feet/high arches	Painful urination	Multiple Sclerosis	_____	
	Prostate trouble			

OTHER:

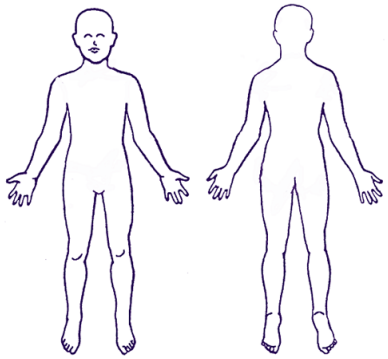
- Cancer/tumors
- Diabetes
- Mental health condition
- Poor nutrition
- Drug/alcohol problems
- Nicotine
- Caffeine

PAIN DIAGRAM

Use the symbols below to indicate the type and location of your sensations right now:

KEY: **XXX** = ACHE /// = BURNING **000** = NUMBNESS +++ = PINS & NEEDLES **SSS** = STABBING

= OTHER (specify) _____



INFORMED CONSENT TO MASSAGE THERAPY AND CARE

I understand that massage is given here for the purpose of stress reduction, relief from muscular tension, spasm or pain, and improving blood circulation to the muscles. I understand that the Massage Therapist does not diagnose illnesses, disease, or any physical or mental disorder. As such, he/she does not prescribe medical treatment or pharmaceutical, nor does he/she perform spinal manipulations. It has been made clear to me that massage is not a substitute for medical examination or diagnoses and that it is recommended that I see a Physician for any ailment that I may have. I will state all my known medical conditions and take it upon myself to keep the Massage Therapist updated on my physical health. I hereby request and consent to the performance of massage therapy.

Patient signature: _____ RMT signature: _____ Date: _____