Massage Therapy Health Scan

Name _____ Birthdate _____

Street, City and Postal Code _____

Phone # and email _____ Emergency contact _____

Physician name & address _____ Accessibility needs? ❒ Yes

Occupation _____ Referred by _____

Reason for visit today? _____ Prior massage therapy? ❒ Yes

Stiffness or pain? Indicate and Rate 0-5

None

0

1

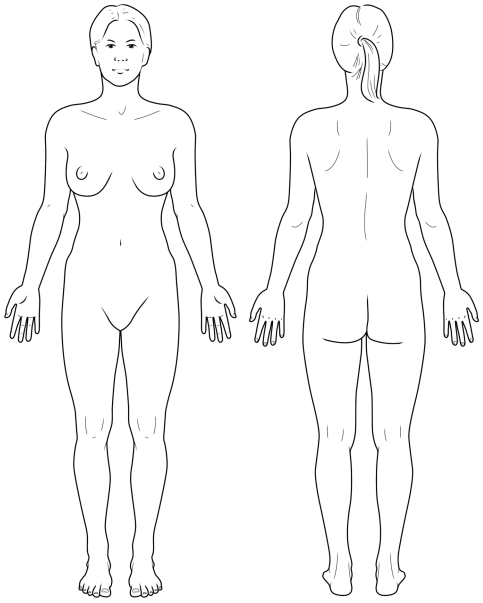
2

3

4

5

Severe



Symptoms / Conditions - Please indicate:

❒ Signs of inflammation - or - infection
❒ Tension headaches or migraines
❒ "Pins & needles" or numbness
❒ Strength or sensory loss of any kind
❒ Muscle or joint pain or stiffness
❒ Hearing or vision loss, balance / coordination
❒ Heart/circulation ❒ High/low blood pressure
❒ Diabetes, or other hormone disorders
❒ Broken bones, artificial joints, pins or plates
❒ Osteo- or rheumatoid arthritis, bone disease
❒ Cuts, warts, open sores, skin irritation
❒ Symptoms of lung, liver, kidney, other organs
❒ Allergies or hyper-sensitivities
❒ Cancer ❒ Auto-immune disorder
❒ Disorders of the brain and nervous system
❒ Anxiety, panic attacks or mood disorder
❒ Any other conditions you wish to disclose:

_____

Describe your general health

Are you physically active? ❒ Yes Sleep well? ❒ Yes

How do your symptoms affect your recreation, work duties and social interaction?

Recent tests/screenings (eg: blood, x-ray, MRI)? ❒ Yes

Other therapies/treatments currently? Pregnant? ❒ Yes

On medication for: ❒ infection ❒ inflammation ❒ pain
❒ muscle spasm ❒ heart and circulation ❒ breathing disorder
❒ impairment of sensation, cognition or proprioception

Details: _____

Please list nature and date of surgeries or severe trauma:

"*I understand my information is held private and confidential and released only with my permission or as required by law*."

_____ _____

Signature Date

Name:

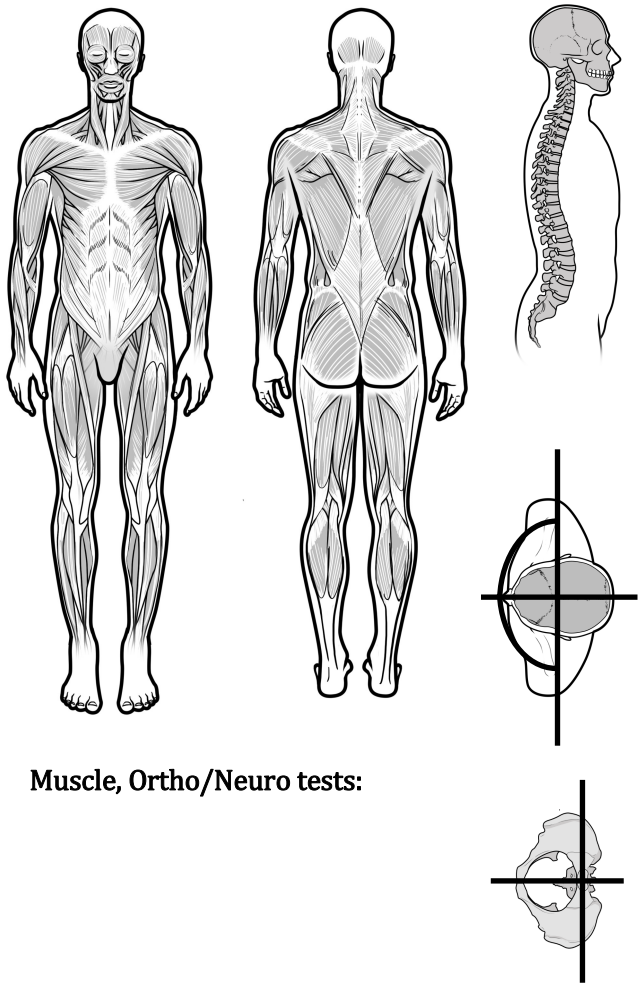
S Subjective / Symptom(s)

- ❒ Location, Intensity, Radiation
- ❒ Onset, Quality, 24 Hour pattern
- ❒ Aggravates, Relieves, Other symptoms
- ❒ Related history, Other Treatment
- ❒ AFX Social, Occupational, Recreational

Yellow & Red Flags

- ❒ Poor general health self-assess
- ❒ Inflammation or infection, skin disease
- ❒ Recent X-rays, medical imaging
- ❒ trauma history
- ❒ Rheumatoid arthritis
- ❒ Bone or muscle disease
- ❒ Medications ℞ allergies/anaphylaxis
- ❒ Steroids or anti-coagulants (long-term)
- ❒ Sensory or motor loss/weakness, MS
- ❒ High/low BP, CVD, diabetes/endocrine
- ❒ Dizziness, severe headaches
- ❒ Dramatic unexplained weight loss
- ❒ Elderly, pregnant or child

O **Objective / Observations:** Posture and Palpation



Muscle, Ortho/Neuro tests:

RMT Professional Opinion: ❒ Muscle spasm/strain ❒ Muscle tension ❒ Myofascial pain/TPs
❒ Postural dysfunction ❒ Joint fixation ❒ Neurovascular entrapment ❒ Outside scope…refer out

App

Preparation
Application
Integration

Ax

Outcomes
Relate to
Observations

P

Plan
Self-Care
Referral

Date: Time: ❒ IVC Visit # Fee $ RMT