

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

Describe your general health

None

0

1

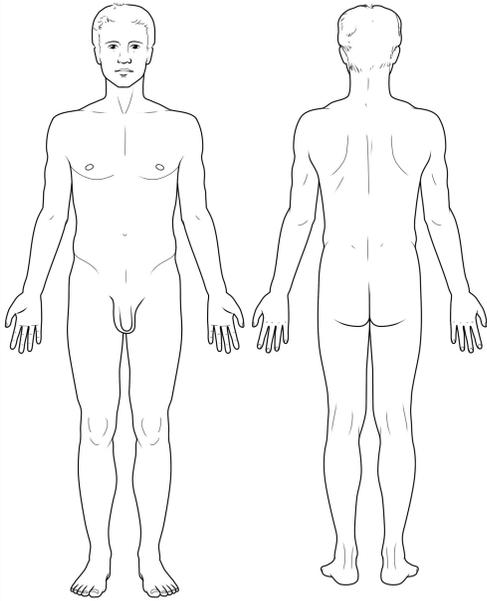
2

3

4

5

Severe



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 receiving?

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:

- 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

S Subjective / Symptom(s)

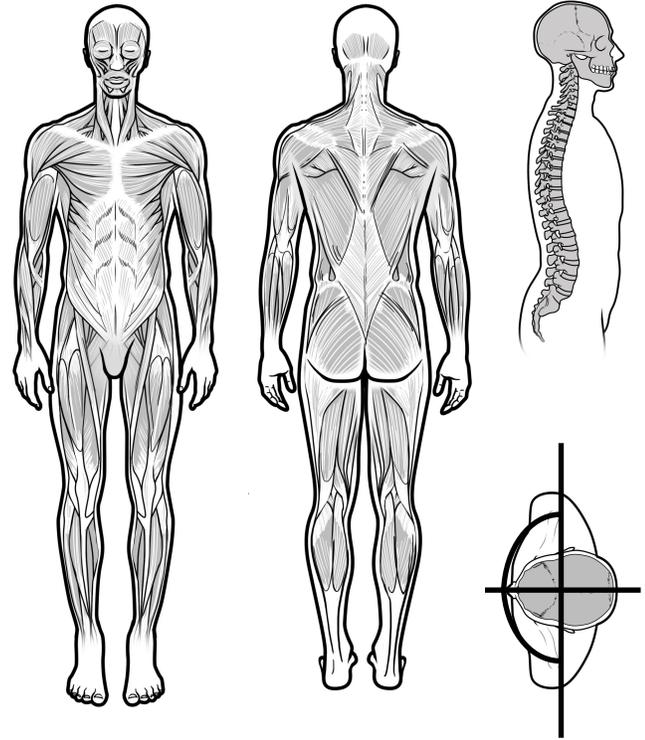
Name: _____

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

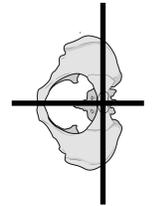
Yellow & Red Flags

- 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 _____