

Massage Therapy Health and Wellness Scan

Name _____ Birthdate _____

Street, City & Postal Code _____

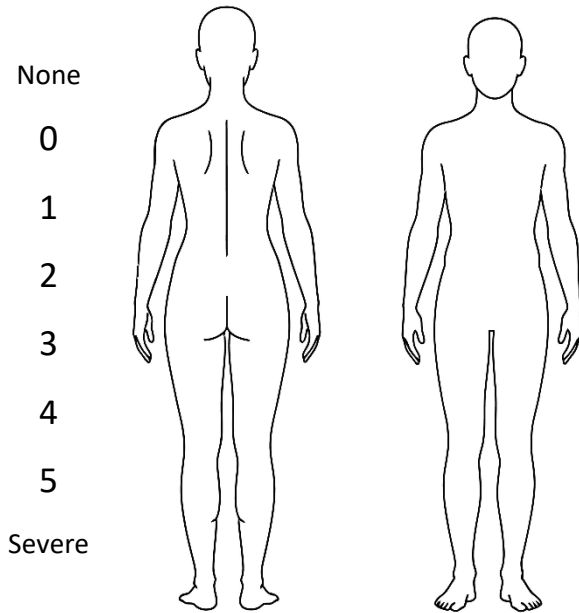
Phone _____ e-mail _____ Emergency contact _____

Physician name & address _____ Accessibility needs? Yes

Occupation _____ Referred by _____

Reason for visit today? _____ Prior massage therapy? Yes

Pain or stiffness? Indicate and Rate 0 - 5



Describe your general health:

Are you physically active? Yes Sleep well? Yes

Do your symptoms affect your recreation work duties or social interaction? How so?

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

Currently receiving other therapies? Yes

Currently on medication? Please check all that apply:

- infection inflammation pain muscle spasm
- heart and circulatory problems breathing disorder
- impairment of sensation, cognition or proprioception

Details:

Surgeries, recurrent injuries or severe trauma? Yes

"I understand I control disclosure of my personal health information. I have the right to ask questions, and to give, withhold or withdraw consent. My information is held private and confidential, and released only with my permission or as required by law."

Signature

Date

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Symptoms & Disorders:

- Signs of inflammation
- Tension headaches or migraines Jaw tension
- Muscle or joint pain, stiffness or impairment
- Broken bones, artificial joints, pins or plates
- Osteo- or rheumatoid arthritis, bone disease
- "Pins & needles" Strength or sensory loss
- Disorders affecting balance and coordination
- Loss of hearing, vision, sense of smell or taste
- Heart/circulation High/low blood pressure
- Diabetes, or other hormone disorders
- Symptoms of lung, liver, kidney, other organs
- Cuts, warts, open sores, skin irritation
- Auto-immune disorder Cancer
- Allergies or sensitivities Infection of any kind
- Physical symptoms caused by mental distress