Confidential Client Information — Clinical Massage Therapy

Name: _____ **Phone: ( ) _____-_____**

Address: _____ **Apt#:** _____

City: _____ **State:** _____ **Zip:** _____ **Date of Birth:** _____

Email: _____ **Referred by:** _____

Occupation: _____ **Reason for visit:** _____

Is the reason for your visit injury related? ❑Yes ❑No Date of Injury: _____/_____/_____

General & Medical Information:

If you answer "yes" to any of the following questions, please explain as clearly as possible.

❑Yes ❑No Have you ever had professional massage?

❑Yes ❑No Are you under the care of a chiropractor? If yes, what is your Doctors name? _____

❑Yes ❑No Have you ever seen a physical therapist for this condition?

❑Yes ❑No Are you pregnant?

❑Yes ❑No Are you wearing contact lenses?

❑Yes ❑No Are you diabetic?

❑Yes ❑No Do you have high blood pressure?

❑Yes ❑No Do you suffer from any allergies? If yes, please list in the comments area of this form

❑Yes ❑No Have you had any broken bones in the past two years?

❑Yes ❑No Have you ever had surgery? If yes, please explain in the comments area of this form.

❑Yes ❑No Do you have cardiac or circulatory problems?

❑Yes ❑No Do you suffer from seizure disorders or epilepsy?

❑Yes ❑No Do you experience frequent headaches?

❑Yes ❑No Do you have any other medical condition that I should be aware of?

❑Yes ❑No Are you currently taking medication(s)? If yes, please list in the comments area of this form.

Please indicate your stress levels: ❑ Low ❑ Medium ❑ High ❑ Extreme

Comments: _____

_____

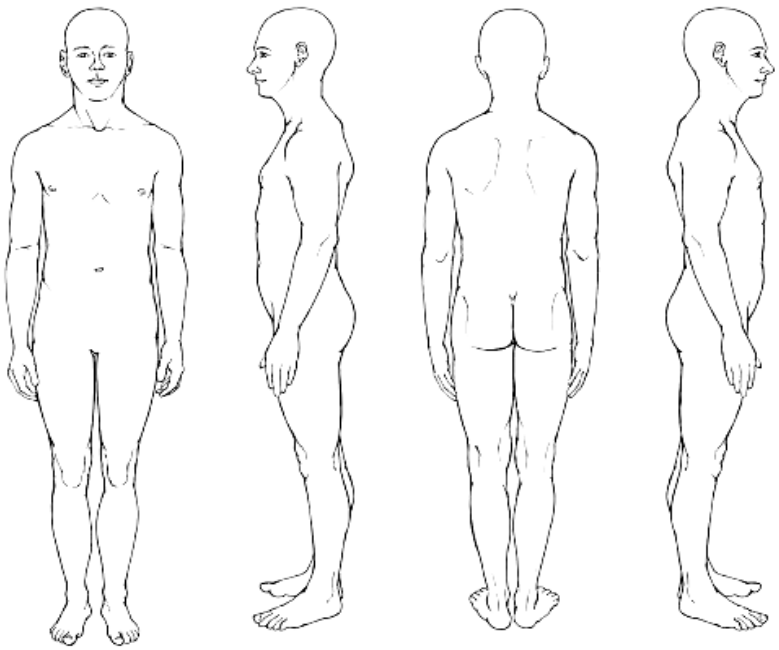
_____

Draw your symptoms on the figures.

1. Identify CURRENT symptomatic areas in your body by marking letters on the figures to the right. Use the letters provided in the key to identify the symptoms you are feeling today.
2. Circle the area around each letter, representing the size and shape of each symptom location.

KEY

P = pain or tenderness
S = joint or muscle stiffness
N = numbness or tingling



Identify the intensity of your symptoms.

1. Pain Scale: On a scale from one (1) to ten (10) please indicate your pain level you are experiencing today. _____ (1 being no pain, 10 being unbearable)

2. Activities Scale: On a scale from one (1) to ten (10) please indicate limitations you are experiencing today in your daily activities. _____ (1 being normal activity, 10 being unable to perform normal daily tasks)

Client Signature: _____ **Date:** _____