MEDICAL MASSAGE INITIAL INTAKE FORM

PATIENT ________________________________ DATE ___________

WAS THIS CASE RELATED TO ____ WORK ____ AUTO ____ OTHER : EXPLAIN ____________________

HOW DID IT HAPPEN? ____

IF IT HAPPENED AT WORK, WAS THE EMPLOYER NOTIFIED? YES _____ NO _____

HAS THE INSURANCE COMPANY BEEN NOTIFIED? YES _____ NO _____

ARE YOU PRESENTLY EMPLOYED? YES _____ NO _____

OCCUPATION ____

IF WORK RELATED, ARE YOU WORKING FOR SAME EMPLOYER? YES _____ NO ______

ARE YOU PRESENTLY UNDER A DOCTOR'S CARE? YES _____ NO ______

HAVE YOU EVER BEEN TREATED FOR THE SAME CONDITION? YES _____ NO ______

WERE YOU ADMITTED TO THE HOSPITAL? YES _____ NO ______

WHAT MAKES YOUR CONDITION WORSE? ____

SURGERY IN THE PAST 5 YEARS? YES _____ NO _____

IF YES, EXPLAIN ____

CHECK THE BOX IF YOU: ___ SMOKE ___ DRINK ALCOHOL ___ DRINK TEA ___ CONSUME CAFFEINE

___ COFFEE ___ EAT CHOCOLATE ___ EAT RED MEAT ___ WEAR CONTACTS

FEMALE PATIENT ONLY: ARE YOU PREGNANT? YES _____ NO _____ DUE DATE: _______________

MEDICAL HISTORY CONSIDERATIONS: DO YOU HAVE

_____ HIGH BLOOD PRESSURE LAST RECORDED MEASUREMENT ___/_____

_____ CONTAGIOUS DISEASES EXPLAIN ANY ____

_____ HEART CONDITIONS EXPLAIN ANY ____

_____ VARICOSE VEINS WHERE? ____

_____ CANCER IN WHICH SYSTEM OR CAVITY? _____________________________

LIST 3 MAJOR HEALTH COMPLAINTS OR MEDICATIONS YOU ARE TAKING

____

____

____

DO YOU HAVE ANY PRE-EXISTING CONDITIONS THAT RELATE TO THIS PRESENT INJURY?

YES _____ NO ____ IF YES, EXPLAIN ____