

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Injury \_\_\_\_\_ ID#/DOB \_\_\_\_\_

**A. Patient Information**

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_

Work \_\_\_\_\_ Cell \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone: Home \_\_\_\_\_

Work \_\_\_\_\_ Cell \_\_\_\_\_

**Primary Health Care Provider**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax \_\_\_\_\_

I give my massage therapist permission to consult with my health care providers regarding my health and treatment.

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_\_

**B. Current Health Information**

List Health Concerns Check all that apply

Primary \_\_\_\_\_

- mild  moderate  disabling
  - constant  intermittent
  - symptoms ↑ w/activity  ↓ w/activity
  - getting worse  getting better  no change
- treatment received \_\_\_\_\_

Secondary \_\_\_\_\_

- mild  moderate  disabling
  - constant  intermittent
  - symptoms ↑ w/activity  ↓ w/activity
  - getting worse  getting better  no change
- treatment received \_\_\_\_\_

Additional \_\_\_\_\_

- mild  moderate  disabling
  - constant  intermittent
  - symptoms ↑ w/activity  ↓ w/activity
  - getting worse  getting better  no change
- treatment received \_\_\_\_\_

**Email** \_\_\_\_\_

**List Daily Activities Limited by Condition**

Work \_\_\_\_\_

Home/Family \_\_\_\_\_

Sleep/Self-care \_\_\_\_\_

Social/Recreational \_\_\_\_\_

**List Self-Care Routines**

How do you reduce stress? \_\_\_\_\_

Pain? \_\_\_\_\_

List current medications (include pain relievers and herbal remedies) \_\_\_\_\_

Have you ever received massage therapy before? \_\_\_\_\_ Frequency? \_\_\_\_\_

What are your goals for receiving massage therapy? \_\_\_\_\_

**C. Health History**

List and Explain. Include dates and treatment received.

Surgeries \_\_\_\_\_

Injuries \_\_\_\_\_

Major Illnesses \_\_\_\_\_

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