NoferTea

Massage and Bodywork

Name:_____Date of Visit:_____

Cell Phone Number_____ Referral Source:_____

Address:_____

Reason for Visit today:_____

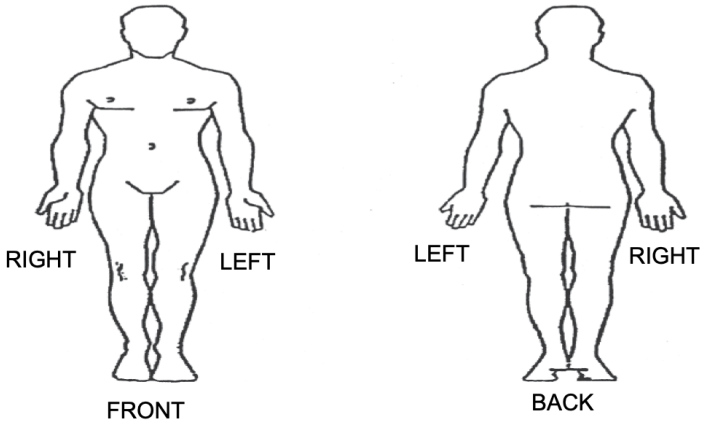
Where is the problem?	What caused it?	What does it feel like?	Do you also have any of the following?
☐ back	☐ don't know	☐ numbness	☐ loss of strength
☐ buttock	☐ lifting something heavy	☐ sharp/stabbing	☐ clumsy hands
☐ legs	☐ long drive/flight	☐ dull ache	☐ trouble walking
☐ neck	☐ car accident	☐ pins/needles	☐ frequent falls
☐ arms	☐ fall	☐ burning	☐ problems with urination or bowels
☐ hands	☐ other_____	☐ cramping	☐ fever/chills
☐ other_____		☐ other_____	☐ can't get to sleep
			☐ pain wakes me up from sleep

How long has this been present? _____days _____weeks _____months _____years

Please rate your pain from 0 (none) to 10 (worst pain): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Mark the areas on your body where you feel the described sensation. Use the appropriate symbol.

Numbness = = = = Stabbing / / / / Aches ^^^^ Pins & Needles ○○○○ Burning x x x x Cramping + + + +



Which side is worse? ☐Left ☐Right ☐Both equal

Which is worse? ☐Leg pain ☐Back pain ☐Both are equal
☐Arm pain ☐Neck pain ☐Both are equal

What makes it better?	What makes it worse?	What medications have you taken for it?	What therapies have you done for it?
☐sitting	☐sitting	☐narcotics	☐chiropractor
☐standing	☐standing	☐anti-inflammatories	☐physical therapist
☐bending	☐bending	☐steroids	☐injections
☐driving	☐driving	☐muscle relaxant	☐brace
☐other_____	☐other_____	☐other_____	☐other_____

How long can you walk? _____minutes _____hours ☐No limit

How long can you sit? _____minutes _____hours ☐No limit

How long can you stand? _____minutes _____hours ☐No limit

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Who have you seen for your current condition?_____
Were any imaging studies completed, if so what type?_____
What did the results indicate?

_____
_____

Please list and date any and all injuries/surgeries here (Even surgeries that seem unrelated)

_____
_____
_____

Please list other medical conditions and original diagnosis date. Include all systems other than musculoskeletal including integumentary, respiratory, circulatory, digestive, excretory, nervous, endocrine, and reproductive.

_____
_____
_____

Do you have a blood clotting disorder or take blood thinners?_____

Please list any medications you are currently taking including OTC.

_____
_____
_____

What goals do you have for today's treatment?

_____
_____

Do you have long term goals related to today's therapeutic massage?

_____
_____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____Date:_____
Parent or Guardian Signature (in case of a minor): _____Date: _____

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