Health History for Radiant Massage Therapy

Name:____ Date of initial visit:_____/_____/_____
Address:_____________________________ City:_________________________ St:______ Zip:________
Home Phone:____________________ Work Phone:__________________ Date of Birth:____/_____/_____
Occupation:_______________________________ Employer:_________________________________
Emergency Contact:____ Phone:___________________
Physician:______________________________ Address:___________________________________
Chiropractor:____________________________ Address:___________________________________
Other provider seen for this specific condition:____
Referral Source (if applicable):____

Do you have difficulty lying on your front, back, or side? Yes No
If yes, please explain____

Do you have allergic reactions to oils, lotions, ointments, or other substances put on your skin, or to any nuts?
Yes No If yes, please explain____

Do you sit for long hours at a work-station, computer, or driving? Yes No
If yes, please describe____

Do you perform any repetitive movement in you work, sports or hobbies? Yes No
If yes, please describe____

Do you experience stress in your work, family or other aspect of your life? Yes No
If yes, has it affected your health? Yes No

Are there particular areas of your body where you are experiencing tension, stiffness or other discomfort?
Yes No If yes, please explain____

Do you have any particular goals for this massage session? Yes No
If yes, please explain____

Are you currently under medical supervision? Yes No
If yes, please explain____

Please list all prescription and over the counter medications, and nutritional/herbal supplements you are taking:
____

Please check and conditions that apply to you (current):

( )Allergies
( )Artificial joint
( )Asthma
( )Atherosclerosis
( )Athlete' foot / fungal infection
( )Cancer / tumors
( )Circulatory disorder
( )Cold sores / herpes
( )Current fever
( )Decreased sensation
( )Diabetes, type I or type II
( )Digestive problems
( )Easy bruising
( )Epilepsy
( )Fractures
( )Hard or severe menstruations
( )Headaches
( )Heart condition
( )High or low blood pressure
( )Joint disorder
( )Lice/scabies
( )Lung or breathing problems
( )Open sores or wounds
( )Phlebitis
( )Psoriasis
( )Rash / eczema
( )Recent accident or injury
( )Recent surgery
( )Rheumatoid arthritis / osteoarthritis
( )Scleroderma
( )Spinal problems
( )Stroke or blood clots
( )Swollen glands
( )Varicose veins

Describe your symptoms and how they began____
____
____

When did your symptoms start?____

How often do you experience your symptoms?
___ Constantly (76%-100% of the day)
___ Frequently (51%-75% of the day)
___ Occasionally (26%-50% of the day)
___ Intermittently (0%-25% of the day)

(Indicate (on attached forms) where you have pain or other symptoms)

What describes the nature of your symptoms?
___ Sharp ___ Dull ache ___Numb ___Shooting ___Burning ___Tingling ___Other
If Other, please describe____

How are your symptoms changing?
___Getting Better ___ Not changing ___Getting worse

Describe changes____

How bad are your symptoms at their: (0=none, 10=unbearable)

Symptom 1:____________________________

Worst:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10

Symptom 2:____________________________

Worst:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform daily activities?

No complaints		Mild, forgotten With activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible
0	1	2	3	4	5	6	7	8	9	10

What activities make your symptoms worse?____
____
____

What activities make your symptoms better?____
____
____

Who have you seen for your symptoms?____
When and what treatment?____
Have you had tests for your symptoms and when were they performed?______________________
Have you had similar symptoms in the past? Yes No

What do you hope to get from this treatment?
____
____

I, ___________________________, understand that the massage therapy given here is for general wellness purposes, including stress reduction, relief from muscular tension or spasm, the promotion of circulation, lymph activity, and flexibility. I understand that a massage therapist does not diagnose illness, disease, or any other physical or mental disorder, and that the massage therapist does not prescribe medical treatment or pharmaceuticals, or perform any spinal manipulations. I understand that I should see a doctor or other appropriate health car provider for diagnosis and treatment of any suspected medical problem. I also understand that it is my responsibility to inform the massage therapist of any existing medical conditions I may have, and keep the massage therapist informed of any changes in my health and medications in the future.

Signature_____________________________