MEDICAL MASSAGE INTAKE FORM

Name: _____ _____
First Last

Home Phone: _____ Cell: _____ Work: _____

Address: _____ City_____ State_____ ZIP_____

Date of Birth: _____ Age: _____ Male: _____ Female: _____

Email: _____ Occupation: _____
Referred by: _____Phone No: _____
(Physician, clinic, neuropath)

Will you be referring to Insurance Yes _____ No ____ Insurance Info Group No: _____

Phone_____
CURRENT HISTORY

1: Primary Complaint (s) _____

_____

2. Other areas of pain or concern: _____ _____

_____

3. When did you notice the primary complaint? _____

4. How did this occur? (accident, movement} _____

5. What aggravates this condition? _____

6. Is this condition getting progressive worse? Yes____ No____ Constant_____ Varies _____

7. When is it most noticeable? Work: _____ Sleep: _____ Daily routine: _____

Dose it prevent you from working? _____

8. What activities or modalities alleviate it: _____

9: Do you have a medical diagnosis: Yes____ No: ____ Diagnosis: _____

10: Do you experience headaches? Yes ____ No____ Frequency____ How long to do they last _____

11. Headache intensity: High _____ Medium _____ Low ____ Location: _____

12: Any trouble with reading or concentration? Yes____ No ____ Frequency ____ Occasionally_____

13. Do you sleep on your Side_____ Stomach _____Back_____ All of the above: _____

Number of hours of sleep at night_____

Blood Pressure Resting: _____ Pulse: _____

Patient Name: _____ _____
First Last

MEDICATIONS: Please list your medications and purpose

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

HABITS:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Weekly Sugar consumption	_____	_____	_____	_____

PAST HISTORY:

Operations: Yes_____ No _____ Type _____ Date _____
Month/Year

Broken Bones: Yes_____ No _____ Type _____ Date _____
Month/Year

AUTOMOBILE ACCIDENT:

1. Name/describe the type of vehicle (size) you were in _____

   Size/type of other vehicle: _____
2. Were both vehicles in motion were you or the other vehicle stationery at the time of the impact?
   _____
3. Approximate speed of impact? _____
4. Were you hit head on _____ from the side ___ or behind? Or did you hit the other car Head on _____ from the side _____ or behind? ____
5. Was there any bruising or marks from the seatbelt? Yes ____ No_____
6. Were you ever unconscious, dizzy or lightheaded after the accident? Yes ____ No _____
7. What was the first noticeable sign or symptoms of whiplash? _____
8. Describe any onset of headaches, neck aches, body aches, open wounds, broken bones or lacerations that you experienced due to/after the accident.

_____
_____