

**Marjorie Brook Massage Therapist
PATIENT HISTORY**

Date: _____

Name: _____ Age: ____ Sex: ____ Birth date: ____/____/____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-Mail Address: _____

Occupation: _____ Referred By: _____

Person to contact in case of an emergency: _____ Phone: _____

What are your major issues or concerns? (List all disorders, symptoms, location and type of pain, in order of importance.) **Date problem began**

1. _____

2. _____

3. _____

Is there a particular motion, action or position that aggravates your pain? Yes No
If yes please explain:

Is there a particular motion, action (stretching, applying heat/ice, medication) or position that relieves your pain? Yes No **If yes please explain:**

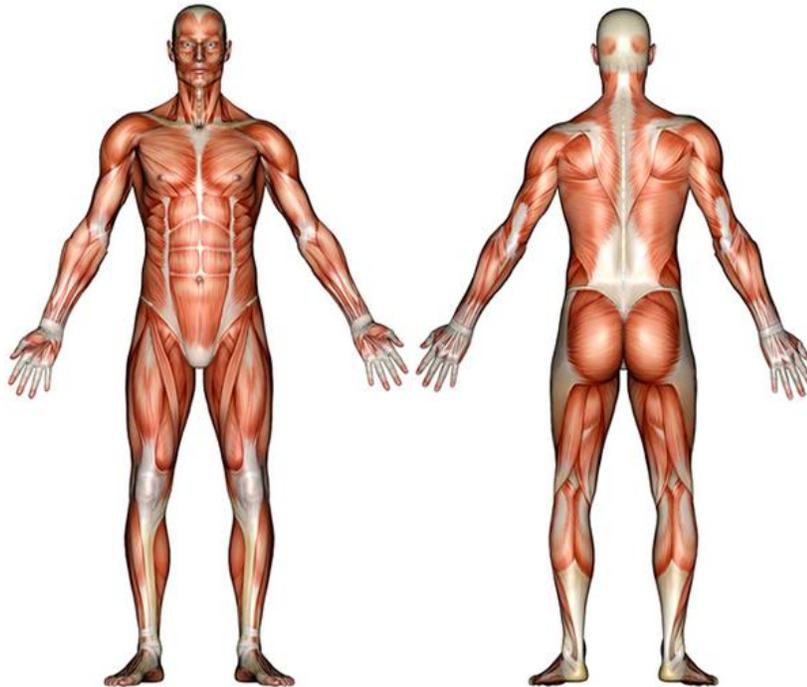
Have you ever had surgery or any medical procedure? If so what kind and when?

Have you ever been in a car accident or have had any other type of trauma? If so when? Please list what kind, if any, treatment you received:

Description of Scar Incident:

Type of Scar: Keloid_____ Hypertrophic_____ Contracture_____ Not Sure_____

Please indicate location of all scars:



PLEASE CHECK ANY ISSUES BELOW THAT APPLY TO YOU :

- ◇ AIDS
- ◇ Allergies (ex. nut allergies) _____
- ◇ Arthritis
- ◇ Back pain, what area: low mid upper
- ◇ Blood clots
- ◇ Broken bones
- ◇ Bruise easily
- ◇ Cancer
- ◇ Cardiac issues
- ◇ Circulatory issues
- ◇ Contagious/infectious disease
- ◇ Dentures
- ◇ Diabetes
- ◇ Depression
- ◇ Diabetes
- ◇ Digestive Disorders
- ◇ Disc/vertebral issues
- ◇ Epilepsy or seizures
- ◇ Headaches, how frequent: often occasionally rarely

- ◇ Fibromyalgia
 - ◇ Frequent stress
 - ◇ Glasses/contacts
 - ◇ Hepatitis
 - ◇ Herpes
 - ◇ High blood pressure
 - ◇ Insomnia
 - ◇ Joint replacements
 - ◇ Joint swelling
 - ◇ Numbness
 - ◇ Osteoporosis
 - ◇ PTSD
 - ◇ Sciatica
 - ◇ Scoliosis
 - ◇ Sensitivity to touch or pressure
 - ◇ Skin Condition
 - ◇ Stroke
 - ◇ Varicose veins
 - ◇ Pregnant, number of weeks:
 - ◇ Tension or Soreness, please specify area: _____
-

Have you had a professional massage? Yes No When was your last massage? _____

Have you had chiropractic care? Yes No When was your last chiropractic session? _____

Have you had acupuncture? Yes No When was your last acupuncture session? _____

Have you had physical therapy? Yes No When was your last physical therapy session? _____

Has there been a time when you have received massages regularly? Yes No

What is your favorite activity or sport? _____

How many times a week do you participate _____

What would you like to achieve with this Therapy/Session?

List all drugs (prescription and non prescription), vitamins, minerals, herbs or other food supplements that you are presently taking on a regular basis. The dosage, duration and reason for taking should be included:

Item	Name of Drug	Dosage	Reason for taking
Antibiotics:	_____	_____	_____
Anti-Seizure Pills:	_____	_____	_____
Anti-Inflammatory Meds:	_____	_____	_____
Birth Control Pills:	_____	_____	_____
Blood Pressure Pills:	_____	_____	_____
Cortisone:	_____	_____	_____
Diuretics:	_____	_____	_____
Laxatives:	_____	_____	_____
Muscle Relaxers:	_____	_____	_____
Mood Elevators:	_____	_____	_____
Sleeping Pills:	_____	_____	_____
Thyroid Medications:	_____	_____	_____
Tranquilizers:	_____	_____	_____
Other:	_____	_____	_____

Do you fill all of your prescriptions at the same pharmacy? Yes No

Do you have prescriptions from more than one Doctor? Yes No

I 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. 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. 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.

Date

Client

