# *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 you 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:**

_____

_____

_____

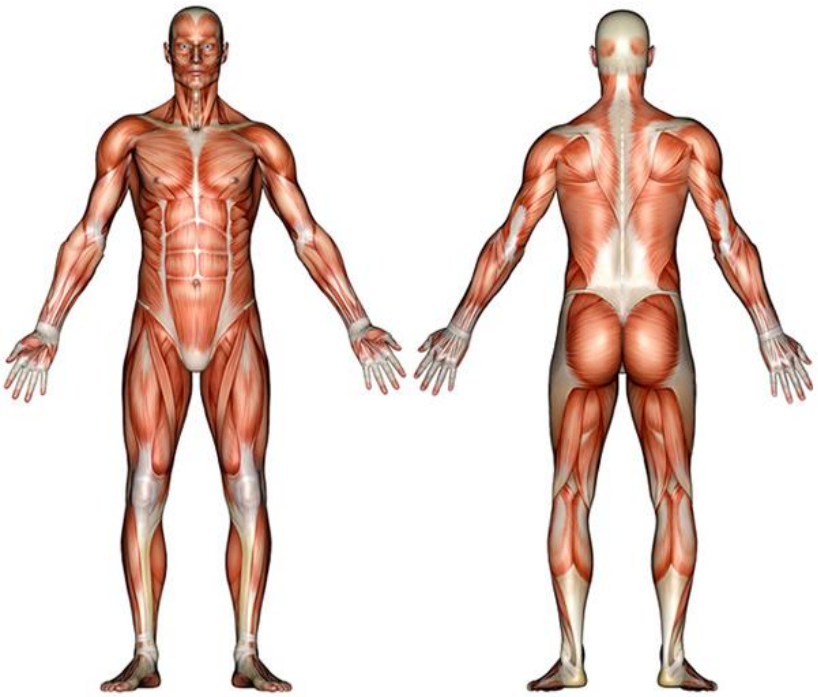
**Description of Scar Incident:**

_____

_____

**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?**

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**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-SeizurePills:_____
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