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?

_____

_____

_____

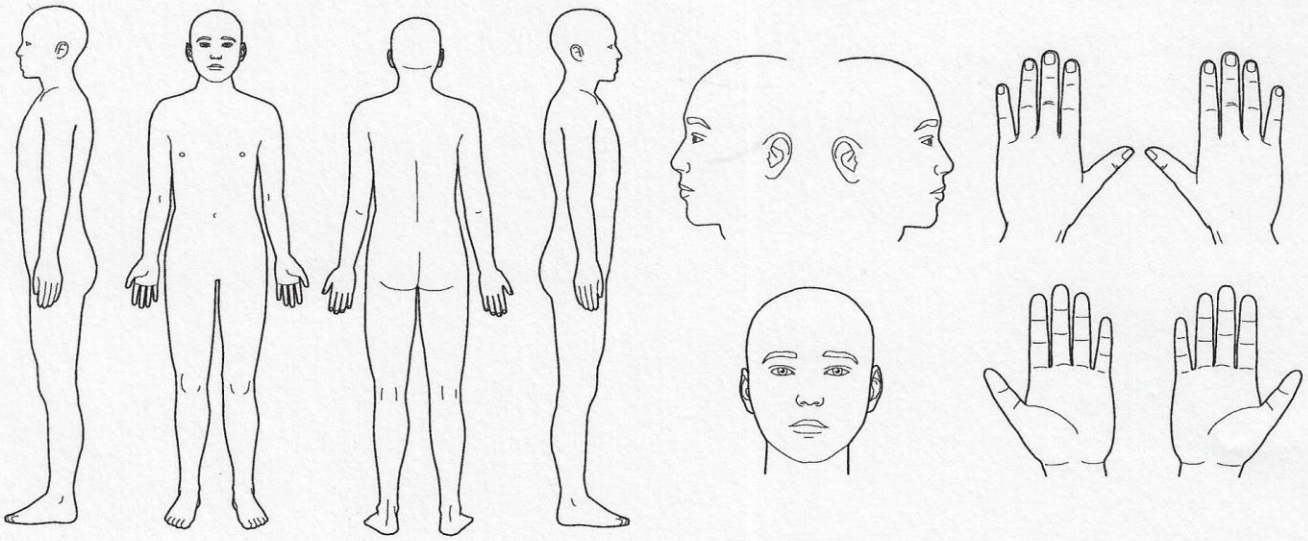
Have you ever been in a car accident or have had any other type of trauma? If so when? Please list what kind, if any, treatment you received:

_____

_____

_____

PLEASE INDICATE ALL SCARS:



	1 = no, not at all … yes, very much = 10
HAS THE SCAR BEEN PAINFUL THE PAST FEW WEEKS?	1 2 3 4 5 6 7 8 9 10
HAS THE SCAR BEEN ITCHING THE PAST FEW WEEKS?	1 2 3 4 5 6 7 8 9 10

	1 = no, as normal skin … yes, very different = 10
IS THE SCAR COLOR DIFFERENT FROM THE COLOR OF YOUR NORMAL SKIN AT PRESENT?	1 2 3 4 5 6 7 8 9 10
IS THE STIFFNESS OF THE SCAR DIFFERENT FROM YOUR NORMAL SKIN AT PRESENT?	1 2 3 4 5 6 7 8 9 10
IS THE THICKNESS OF THE SCAR DIFFERENT FROM YOUR NORMAL SKIN AT PRESENT?	1 2 3 4 5 6 7 8 9 10
IS THE SCAR MORE IRREGULAR THAN YOUR NORMAL SKIN AT PRESENT?	1 2 3 4 5 6 7 8 9 10

	1 = as normal skin … very different = 10
WHAT IS YOUR OVERALL OPINION OF THE SCAR COMPARED TO NORMAL SKIN?	1 2 3 4 5 6 7 8 9 10

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-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