Initial Evaluation For Massage Therapy

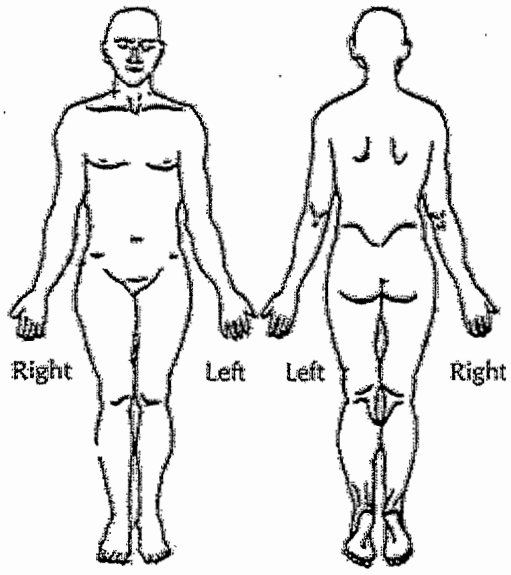
Today's Date: _____

Name: _____ DOB: _____

Date of Injury: _____

Do you CURRENTLY have pain as a result of this injury? (Circle one): YES NO

If yes, please mark the areas where you have pain on the body chart below.



If you have pain in more than one major area of the body, please list which area is your primary and/or secondary concern:

1. _____
2. _____
3. _____
4. _____

How would you describe your pain? (Circle ALL that apply):

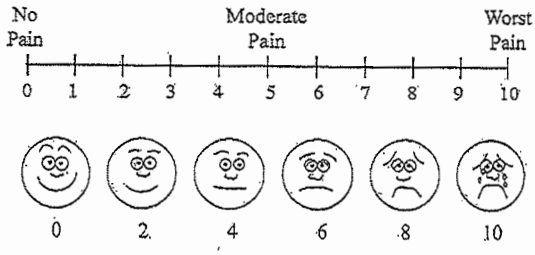
ACHE STIFFNESS SHARP BURNING PULSATING OTHER: _____

Is your pain CONSTANT or INTERMITTENT? (Circle one)

Using the pain scale below please rate how your pain varies in a typical day:

Worst pain level (i.e. with activity or when NOT using pain medication): _____

Lowest pain level (i.e. at rest or when using pain medication): _____



Do you have any headaches associated with this injury? (Circle one): YES NO

Do you have any numbness or tingling associated with this injury? (Circle one): YES NO

If yes, please describe: Where?_____

When?_____

How often?_____

Do you have any increased pain with DEEP BREATHING, COUGHING or SNEEZING? (Circle any that apply)

Have there been any changes in your BOWEL or BLADDER function associated with this injury? (For example: loss of control or inability to go) (Circle one): YES NO

If yes, please describe:_____

What positions, movements or activities aggravate your pain? (i.e. What makes your pain worse?):

_____

_____

What have you tried thus far that alleviates your pain, even if only temporarily? (i.e. What makes you feel better?):

_____

_____

Are your symptoms typically worse in the MORNING, MID-DAY or EVENING? (Circle one)

Is your sleep interrupted due to pain or discomfort from this injury? (Circle one): YES NO

Occupation: _____

Currently Working (Circle one): YES NO

If yes (Circle one): REGULAR DUTY MODIFIED DUTY

If on modified work duty, list your current work restrictions recommended by your primary doctor for this injury: _____

_____

If you are NOT working, please provide the reason (Circle one):

DOCTORS ORDER MODIFIED DUTY NOT AVAILABLE WITH EMPLOYER

NO LONGER WORKING (i.e. quit, fired, laid off)

OTHER: _____

What are the physical requirements of your REGULAR work?

LIFTING/CARRYING: _____lbs (maximum weight lifted/carried by yourself)

PUSHING/PULLING: _____lbs (maximum weight push/pull by yourself)

Circle any additional physical requirements of your REGULAR job:

REACH CLIMB SQUAT STOOP/BEND TWIST

STAIRS/STEPS KNEEL CRAWL BALANCE

OTHER: _____

Since the onset of your injury, overall would you say your pain is: (Circle one)

GETTING WORSE STAYING THE SAME GETTING BETTER

Have you ever injured this area(s) before? (Circle one) YES NO

If yes, please provide details:

When: _____

Treatment Received: _____

Did you fully recover? (Circle one) YES NO

If no, what symptoms remained? _____

Please provide details of any medical intervention, evaluation or treatment have you had thus far. For example: when, where, what type of treatment, was it effective?

ER/Urgent Care: _____

Primary Care Physician: _____

Occupational Medicine Physician: _____

Specialist: _____

Physical Medicine: CHIROPRACTIC PHYSICAL THERAPY ACCUPUNCTURE MASSAGE

OTHER: _____

Have you had any diagnostic imaging for this injury? (Circle one) YES NO

If yes, please provide details:

Type of imaging: X-RAYS MRI CT SCAN OTHER: _____

Date(s): _____

Results/Findings: _____

Since the onset of your injury, overall would you say your pain is: (Circle one)

GETTING WORSE STAYING THE SAME GETTING BETTER

Have you ever injured this area(s) before? (Circle one) YES NO

If yes, please provide details:

When: _____

Treatment Received: _____

Did you fully recover? (Circle one) YES NO

If no, what symptoms remained? _____

Do you have any other health conditions, illnesses or injuries that could affect your treatments or exercise? (Circle one) YES NO

(Circle all that apply)

HIGH BLOOD PRESSURE DIABETES HEART DISEASE COPD ASTHMA ARTHRITIS PREVIOUS POSITIVE COVID DIAGNOSIS CSF PRESSURE ISSUES/CHIARI MALFORMATION KIDNEY DISEASE JOINT PROBLEMS PAIN/MOBILITY ISSUES (unrelated to this injury) PREGNANCY EDEMA VARICOSE VEINS THROMBOSIS OSTEOPOROSIS

OTHER: _____

Please list any prescription or non-prescription medications or supplements you are currently taking: _____

_____

Have you had professional massage/bodywork OFTEN RARELY NO

Do you have a latex allergy? (Circle one) YES NO

Please initial:

_____ I understand that my success in Massage Therapy requires a collaborative effort between myself, my massage therapist and my doctor(s).

_____ I understand Massage Therapy requires my full participation in treatments including attending my appointments as scheduled, actively participating in any stretching and strengthening exercises recommended.

_____ I understand that in addition to treatment in the clinic I also have a responsibility to learn how to care for myself/my injury at home for optimal outcome.

X_____

PRINT NAME

X_____ _____

SIGN NAME DATE