PHYSICAL THERAPY @ THE PACIFIC CLINIC
1350 NORTH GRANT STREET KENNEWICK, WA 99336 PHONE: (509) 735-2014 FAX: (509) 735-3980

MASSAGE THERAPY MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____

OCCUPATION: _____

THE FOLLOWING INFORMATION WILL BE USED TO HELP PLAN SAFE AND EFFECTIVE MASSAGE SESSIONS. PLEASE ANSWER TO THE BEST OF YOUR KNOWLEDGE.

1. HAVE YOU HAD A PROFESSIONAL MASSAGE BEFORE? YES NO

   IF YES, HOW OFTEN DO YOU RECEIVE MASSAGE THERAPY? _____
2. DO YOU HAVE DIFFICULTY LYING ON YOUR FRONT, BACK OR SIDE? YES NO

   IF YES, PLEASE EXPLAIN _____
3. DO YOU HAVE ANY ALLERGIES TO OILS, LOTION OR OINTMENTS? YES NO

   IF YES, PLEASE EXPLAIN _____
4. DO YOU HAVE SENSITIVE SKIN? YES NO
5. ARE YOU WEARING ( ) CONTACT LENSES ( ) DENTURES ( ) HEARING AIDS?
6. DO YOU SIT FOR LONG HOURS AT A WORKSTATION, COMPUTER OR DRIVING? YES NO

   IF YES, PLEASE EXPLAIN _____
7. DO YOU PERFORM ANY REPETITIVE MOVEMENT IN YOUR WORK, SPORTS OR HOBBIES? YES NO

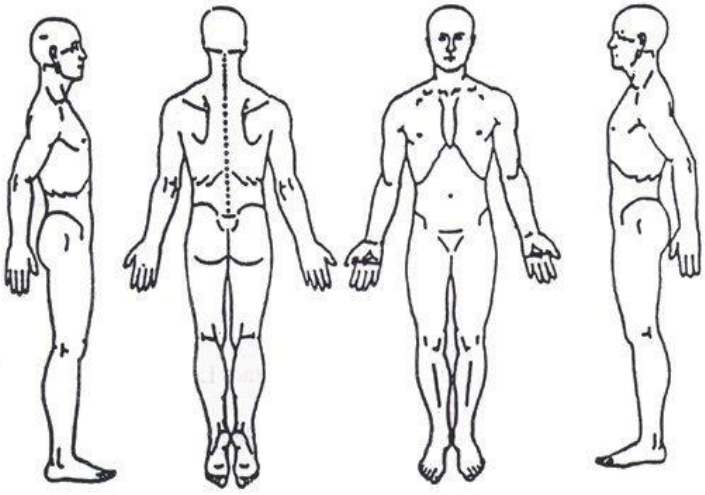
   IF YES, PLEASE EXPLAIN _____
8. DO YOU EXPERIENCE STRESS IN YOUR WORK, FAMILY OR ANY OTHER ASPECTS OF YOUR LIFE? YES NO

   IF YES, HOW DO YOU THINK IT AFFECTS YOUR HEATH?

   ( ) MUSCLE TENSION ( ) ANXIETY ( ) INSOMNIA ( ) IRRITABILITY ( ) OTHER _____
9. IS THERE A PARTICULAR AREA OF THE BODY WHERE YOU ARE EXPERIENCE TENSION, STIFFNESS, PAIN OR ANY OTHER DISCOMFORT? YES NO

   IF YES, PLEASE IDENTIFY _____
10. DO YOU HAVE ANY PARTICULAR GOALS IN MIND FOR THIS MASSAGE SESSION? YES NO

    IF YES, PLEASE EXPLAIN _____



CIRCLE AREAS YOU WOULD LIKE TO FOCUS ON DURING YOUR SESSION.

11. ARE YOU CURRENTLY UNDER MEDICAL SUPERVISION? YES NO

IF YES, PLEASE EXPLAIN _____

12. DO YOU SEE A CHIROPRACTOR? YES NO

13. ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES NO

IF YES, PLEASE LIST _____

14. PLEASE CHECK ANY CONDITION LISTED BELOW THAT APPLIES TO YOU:

( ) CONTAGIOUS SKIN CONDITIONS
( ) OPEN SORES OR WOUNDS
( ) EASY BRUISING
( ) RECENT ACCIDENT OR INJURY
( ) RECENT FRACTURE
( ) RECENT SURGERY
( ) ARTIFICIAL JOINT
( ) SPRAINS/STRAINS
( ) CURRENT FEVER
( ) SWOLLEN GLANDS
( ) ALLERGIES/SENSITIVITY
( ) HEART CONDITION
( ) HIGH OR LOW BLOOD PRESSURE
( ) CIRCULATORY
( ) VARICOSE VEINS
( ) ATHEROSCLEROSIS
( ) PHLEBITIS
( ) DEEP VEIN THROMBOSIS/BLOOD CLOTS
( ) EPILEPSY
( ) HEADACHES/MIGRAINES
( ) CANCER
( ) DIABETES
( ) DECREASED SENSATION
( ) BACK/NECK PROBLEMS
( ) FIBROMYALGIA
( ) TMJ
( ) CARPAL TUNNEL SYNDROME
( ) TENDONITIS
( ) OSTEOPOROSIS
( ) ARTHRITIS
( ) JOINT DISORDER
( ) PREGNANT, HOW MANY MONTHS? _____

PLEASE EXPLAIN ANY CONDITION THAT YOU HAVE MARKED ABOVE: _____

_____

_____

15. IS THERE ANYTHING ELSE ABOUT YOUR HEALTH HISTORY WE SHOULD KNOW? _____

_____

_____

DRAPING WILL BE USED DURING THE SESSION – ONLY THE AREA BEING WORKED ON WILL BE UNCOVERED.

PATIENTS UNDER THE AGE OF 17 WILL FOLLOW CCPT'S "TREATMENT OF MINOR" POLICIES.

I ACKNOWLEDGE THAT MASSAGE THERAPY IS NOT A SUBSTITUTE FOR MEDICAL CARE, MEDICAL EXAMINATION OR DIAGNOSIS. I HAVE STATED ALL MEDICAL CONDITIONS THAT I AM AWARE OF AND WILL INFORM MY PRACTITIONER OF ANY CHANGES IN MY HEALTH STATUS.

PATIENT SIGNATURE: _____ DATE: _____