Comprehensive
PHYSICAL THERAPY
& Fitness

Massage Clients Medical History

Medical History

Patient's name: ____ Date: _________________

Current Condition:

What is the problem you are here for? ____
____

What is the date the problem started? ________________

Have you had similar symptoms in the past? ☐ Yes ☐ No If Yes, when? ____/______/______

What is your occupation? __________________________________

Current work status: ☐Full time ☐Part time ☐Self-employed ☐Retired ☐Off work ☐Other_______________

Have you seen anyone else for your current condition (check box/boxes)?

☐Physician/MD ☐Chiropractor ☐Podiatrist ☐Ortho surgeon ☐Massage
☐Dentist ☐Neurologist ☐Physical Therapist ☐Other ____________

Doctor/Therapist/Dentist/Practice Name:____

Past medical History:

Have you ever had any of the following conditions? Check all that apply.

☐Alcohol use ______________
☐Alzheimer's / Dementia
☐Asthma
☐Bowel/Bladder problems
☐Cancer History____________
☐Cardiovascular Disease
☐Cerebral Vascular Accident
☐Current Infection
☐Depression / Anxiety _____________
☐Diabetes Type 1 or Type 2
☐Fainting/dizziness
☐Fall(s) History____________
☐Fibromyalgia
☐Fracture or Suspected Fracture
☐Headaches
☐Hearing problems
☐Heart condition
☐High blood pressure
☐Lung problems___________
☐Osteoarthritis
☐Osteopenia
☐Osteoporosis
☐Peripheral neuropathy
☐Rheumatoid arthritis
☐Seizures/epilepsy
☐Stroke
☐Thyroid problems
☐Tobacco use_____________
☐Vision problems
☐Other___________________

Please list any **current Medications** (include over the counter meds) and **Supplements**, please include specific dosages of each medication / supplement. You may provide a list to attach.

Meds / Supplement	Dosage	Frequency	Route				Comments
			☐Oral	☐Inject	☐Dermal	☐Rectal	
			☐Oral	☐Inject	☐Dermal	☐Rectal	
			☐Oral	☐Inject	☐Dermal	☐Rectal	
			☐Oral	☐Inject	☐Dermal	☐Rectal	
			☐Oral	☐Inject	☐Dermal	☐Rectal	

Please list all surgeries (include approximate date):

Type of Surgery	Appx Date	Comment

Please list all allergies

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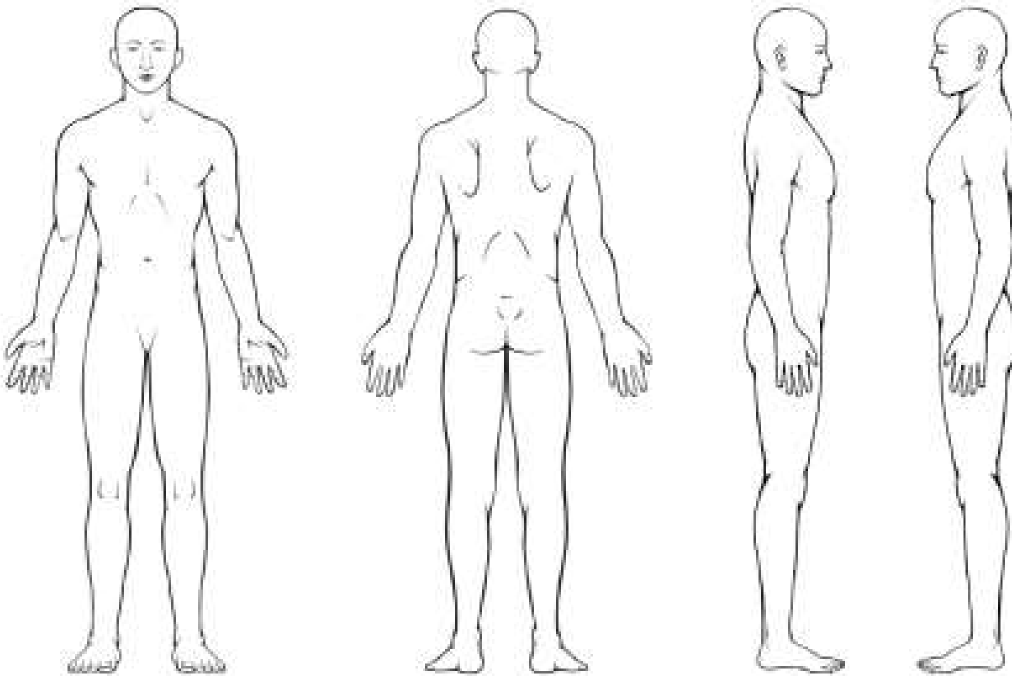
Patient name: ____ Date:_________________________

Please draw/mark where your pain is on the below body diagram (use symbols below to represent your pain).

Numbness - - - - - -   Burning xxxxxx   Aching ooooooo   Stabbing /////////



Rate your pain on the following scale (0 being no pain at all and 10 the worst imaginable pain ever):

Rate what it has been in the last 24 hours.

Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10