Magna Physical Therapy &
Sports Medicine Center LLC

Medical History Massage

Name: ______________________________ **Date:** ______________________________

Have you RECENTLY noted any of the following? (check all that apply)

☐ Headaches
☐ Fever/chills/sweats
☐ Nausea/vomiting
☐ Weight loss/gain
☐ Difficulty with balance
☐ Shortness of breath
☐ Numbness/tingling
☐ Muscle weakness
☐ Dizziness/lightheaded
☐ Heartburn/indigestion
☐ Difficulty swallowing
☐ Bowel/bladder changes
☐ Diarrhea or constipation
☐ Falls
☐ Fainting
☐ Cough
☐ Fatigue
☐ Infection

Have you EVER been diagnosed with any of the following conditions? (check all that apply)

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Bone/joint infection
☐ Asthma
☐ Autoimmune disorder
☐ Cancer
☐ Cardiac/heart problems
☐ Arrhythmia
☐ Chest pain/angina
☐ Pacemaker or defibrillator
☐ Chemical dependency
☐ Circulation/vascular problems
☐ Blood or clotting disorders
☐ Raynaud's disease
☐ Depression
☐ Diabetes
☐ Dizzy spells
☐ Emphysema/bronchitis
☐ Lung problems
☐ Pneumonia
☐ Fibromyalgia
☐ Fractures
☐ Gallbladder problems
☐ Headaches
☐ Hearing impairment
☐ Hepatitis
☐ Liver problems
☐ High cholesterol
☐ High blood pressure
☐ Low blood pressure
☐ Sexually transmitted infection
☐ Pelvic inflammatory disease
☐ HIV/AIDS
☐ Incontinence
☐ Kidney problems
☐ Urinary tract/bladder infection
☐ Metal implants
☐ MRSA
☐ Multiple sclerosis
☐ Muscular disease
☐ Osteopenia or osteoporosis
☐ Parkinson's
☐ Rheumatoid arthritis
☐ Seizures/epilepsy
☐ Smoking/tobacco use
☐ Speech problems
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Vision problems

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions? (check all that apply)

☐ Cancer
☐ Diabetes
☐ Tuberculosis
☐ Heart problems
☐ Stroke
☐ Thyroid problems
☐ High blood pressure
☐ Depression
☐ Blood clots

Name: ______________________________

During the past month have you been feeling down, depressed or hopeless? ☐**Yes** ☐**No**

During the past month have you been bothered by having little interest or pleasure in doing things? ☐**Yes** ☐**No**

Is this something with which you would like help? ☐**Yes** ☐**No**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?☐**Yes**☐**No**

Please list any allergies:

______________________________ Response: ____________________

______________________________ Response: ____________________

Please list any surgeries you have had:

______________________________ Date: ____________________

______________________________ Date: ____________________

Please list any medications you are currently taking or attach a medication list:

Drug	Dose	Frequency	Reason

Massage Experience:

Have you ever had a professional massage before? ❑**Yes** ❑**No**

If yes, when was your last massage? ______________________________

Do you have any allergies to lotion/oils or skin sensitivities? ______________________________

Do you have any difficulty lying on your stomach, back, or side? ❑**Yes** ❑**No**

If yes, please explain: ______________________________

Are you currently pregnant? ❑**Yes** ❑**No**

Do you currently exercise? ❑**Yes** ❑**No**

If yes, what types and how often? ______________________________

Do you have any current injuries? ❑**Yes** ❑**No**

If yes, please explain: ______________________________

What are your goals for treatment? ______________________________

Client/Patient/Guardian Signature:

______________________________ Date: ____________________