Hands On Physical Therapy, LLC.
3898 New Vision Drive Ste. D
Fort Wayne, IN 46845

Tel: 260-483-1010
Fax: 260-483-1011

Massage Intake Form

Client name: _____ Date: _____/_____/_____
Address _____City_____State____Zip Code_____
Phone: (home) _____(work)_____(cell)_____
DOB: _____Occupation_____
How did you hear about us?_____Referred by_____

THE FOLLOWING IS VERY IMPORTANT IN OUR CLINICAL ASSESSMENT. PLEASE FILL OUT THESE FORMS AS SPECIFICALLY AS POSSIBLE TO PROVIDE US WITH A CLEAR PICTURE OF YOUR PRESENT CONDITION AND SYMPTOMS.

1. What is your primary complaint that brings you to our center? Please describe your symptoms as specifically as possible.

2. On what date did your symptoms begin: _____
3. How did your symptoms begin? For example, did your symptoms begin as a result of an accident of trauma, or did they begin without a known reason?

4. Do you have any of the following medical conditions?

	YES	NO		YES	NO
Circulatory problems	___	___	Stroke	___	___
Blood clots	___	___	Blackouts	___	___
High Blood Pressure	___	___	Visual disturbances	___	___
Heart trouble	___	___	Weight changes > 15#	___	___
Pacemaker	___	___	Headaches	___	___
Epilepsy	___	___	Ringing in Ears	___	___
Diabetes	___	___	Bowel/Bladder problems	___	___
Pregnancy	___	___	Malignancy	___	___

5. Past Medical History: Please list any surgeries, traumas, accidents, or other conditions along with the dates.

6. **Have you ever had a professional massage? YES/NO**
   Have you ever received Myofascial Release? YES/NO

7. **WHAT ARE YOUR TREATMENT GOALS?**

Massage Therapy/Bodywork Waiver

I, _____, understand that massage therapy/bodywork given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. I understand that massage therapy/bodywork is not a substitute for medical examination and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical, mental, and emotional health.

SIGNATURE: _____ Date _____

WITNESS: _____ Date _____

PLEASE PLACE A √ IN FRONT OF EACH ITEM THAT YOU EXPERIENCE AT LEAST MONTHLY. PLACE AN X IN FRONT OF EACH ITEM THAT YOU EXPERIENCE WEEKLY OR MORE FREQUENTLY.

___ Headaches (type)
___ Heart pounding or racing
___ Irregular heart beat
___ Chest pain, tightness
___ Numbness, tingling in arm or leg
___ Can't keep warm
___ Sweaty palms
___ Blushing, flushing face
___ Coughing
___ Stuffy nose, congestion
___ Earache or ringing noise in ears
___ Common colds
___ Sore throat
___ Asthma or shortness of breathe
___ Hay fever or allergies
___ Sore, aching muscles
___ Stiff or tender joints
___ Back problems
___ Trembling/ twitching muscles
___ Skin rashes, eruptions
___ Grinding of teeth (TMJ)
___ Dry mouth
___ Mouth Sores
___ Excessive perspiration
___ Difficulty falling asleep
___ Difficulty sleeping through the night
___ Awaken too early in the morning
___ Excessive drowsiness during day
___ Periods of extreme fatigue
___ Feeling faint of dizzy
___ Feeling tense or nervous
___ Difficulties with family or friends
___ Worrisome thoughts
___ Recurring bad thoughts
___ Thoughts of suicide
___ Fearful of persons or places

___ Feeling inadequate/unable to cope
___ Feeling guilt or failure
___ Uncontrolled crying or sadness
___ Easily annoyed or irritated
___ Free-floating anxiety about life
___ Voice quivering, shaking
___ Eyes irritated or inflamed
___ Vision blurred
___ Eyestrain or discomfort
___ Nosebleeds
___ Stomach Cramps
___ Heartburn, indigestion
___ Nausea or vomiting
___ Frequent urination
___ Incomplete urination
___ Painful urination
___ Urinary leakage
___ Bowel leakage
___ Gas in lower bowel
___ Diarrhea
___ Constipation
___ Bowel irregularity
___ Uninterested in sex relations
___ Unable to enjoy sex relations
___ Unable to participate in sex acts
___ Menstrual difficulties
___ Pre-menstrual syndrome
___ Breast tenderness
___ Hot Flashes
___ Water retention
___ Over-eating, bingeing
___ Lack of appetite
___ Excessive alcohol abuse
___ Other substance abuse
___ Frequent laxative use
___ Other:

****Medications:** please indicate below ALL medications which you are currently taking, the problem for which you are using them and the dose and their effectiveness:

Medication:	**For Treatment of:**	**Dose/Amt/Day**	**Effectiveness**

THE FOLLOWING IS VERY IMPORTANT IN OUR EVALUATION PROCESS. PLEASE FILL OUT THESE FORMS AS SPECIFICALLY AS POSSIBLE TO PROVIDE US WITH A CLEAR PICTURE OF YOUR PRESENT FUNCTIONAL ABILITY AND SYMPTOMS.

1. Below you will find a list of common activities that patients have difficulty performing because of their symptoms. For each activity, please note the amount of time in minutes or hours that you can perform the activity before you feel that you need to stop because of your symptoms. If you have no difficulty with the activity, mark "OK". If you are unable to perform the activity mark "Unable".

ACTIVITY	TOLERANCE	ACTIVITY	TOLERANCE
Sitting	_____	Computer work	_____
Standing	_____	Exercise	_____
Walking	_____	Writing	_____
Stairs (# or flights)	_____	Shopping	_____
Driving	_____	Bending	_____
Sleeping	_____	Reaching (# reps)	_____
Household Chores	_____	Lifting (# of lbs.)	_____
Cooking	_____	Carrying (# of lbs.)	_____
Laundry	_____	Other_____	_____
Dishwashing	_____	_____	_____

2. WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY? For example, what activities from the above list would you like to be able to perform better or longer? How long in minutes or hours do you need or want to perform each activity?

3. On the lines below, place a slash amrech to indicate your functional ability as % of normal.

On a good day 0%_____100%

On a bad day 0%_____100%

4. What is your primary compliant that brings you to therapy? Please describe your symptoms as specific as possible.

   Secondary Complaint?

5. On what date did your symptoms begin? _____

6. How did your symptoms begin? For example did your symptoms begin as a result of an accident or trauma, or did they begin without a known reason?

7. Put a slash mark on the line below to rate INTENSITY of your symptoms:

No pain _____Worst Pain imaginable

Put a slash mark on the line below to rate the FREQUENCY of your symptoms:

No pain _____Constant Pain

8. Do you have any of the following medical conditions?

	YES	NO		YES	NO
Circulatory problems	___	___	Stroke	___	___
Blood clots	___	___	Blackouts	___	___
High Blood Pressure	___	___	Visual disturbances	___	___
Heart trouble	___	___	Weight changes > 15#	___	___
Pacemaker	___	___	Headaches	___	___
Epilepsy	___	___	Ringing in Ears	___	___
Diabetes	___	___	Bowel/Bladder problems	___	___
Pregnancy	___	___	Malignancy	___	___

9. Past Medical History: Please list any surgeries, traumas, accidents, or other conditions along with the dates.