MUSCULAR THERAPIES, LLC
RELIEF FOR PROBLEM MUSCLES

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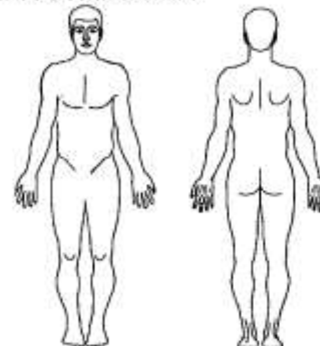
Patient Name: ______________________ Birthdate: __________ Sex: M / F
Address ______________________ City ______________
State ______ Zip __________ Telephone (____)__________ Patient Primary Language ______________
Occupation: ______________ Employer: ______________ Work Phone: ______________
E-mail address: ______________________ Referred by: ______________________
Emergency Contact Name ______________________ Telephone (__)______________
Massage Info: First Professional Massage: ☐ Yes ☐ No How Frequently: ______________
Primary Care Physician Name: ______________________ PCP Phone: ______________

MARK AN **X** ON THE PICTURE BELOW WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:
☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain
☐ Other______________________

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began:______________________
How Problem Began:

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken: ______________ **What areas were taken?** ______________

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) ______________
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) ______________
____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain) ______________
____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks______________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries______________
____
____
☐ Medications:______________
____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

Additional Information: ______________________
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I attest that the above information is accurate. I understand that Licensed Massage Therapists do not diagnose disease or prescribe drugs and that they are not a substitute for medical care. I agree to alert my practitioner of any physical/emotional changes as they occur. I also understand that a missed appointment might incur charges that I must pay.

Signature: ______________________ Date: ______________