A Touch Above Massage Therapy

Patient Information & History

Last Name: _____ First Name: _____ MI __

_____Male _____ Female Age: _____

Please check NO or YES for those conditions that apply to you.

History of high or low blood pressure?	Y or N	Previous neck or back problems?	Y or N
History of heart or blood vessel disease?	Y or N	Currently have visual / hearing problems?	Y or N
Previous heart attacks?	Y or N	Any sensory disturbances?	Y or N
Previous strokes – CVA?	Y or N	History of cancer? When ?	Y or N
Currently have a pacemaker?	Y or N	Any unusual reactions to heat or cold?	Y or N
Diabetes?	Y or N	Any broken bones?	Y or N
Arthritis or any other joint problems	Y or N	Any allergies? Please list.	Y or N
Presently have any metal implants?	Y or N	Other	Y or N

If you have answered yes to any of the above questions, please describe further:

_____

_____

List current medications: _____

_____

List previous hospitalizations / surgeries (especially those within the last 6 months) and diagnosis: _____

_____

_____

Describe your chief complaint or problem requiring therapy services: _____

_____

Describe any prior therapy related to this condition (when, how long and the outcome):

_____

_____

What was your prior activity level, including recreational activities?

_____

_____

Please check if you have started to have difficulty with any of the following functional abilities:

____ Eating	____ Walking with / without assistive device	____ Swallowing foods
____ Dressing	____ Balance	____ Swallowing liquid
____ Grooming	____ Mobility	____ Speaking clearly
____ Bathing	____ Getting from bed to chair	____ Expressing needs / wants
____Toileting	____ Standing up from bed or chair	