massage therapy case history

amt
association of
massage therapists
in good hands

PERSONAL DETAILS

Current Date:

Name:

Address:

Phone (home):

Phone (work/mobile):

DOB:

Occupation:

Referred by:

Health Fund:

Emergency contact details:

Details of previous professional massage:

Expectations of this massage:

Exercise habits:

General diet:

Intake of:

Caffeine -

Alcohol -

Water -

Cigarettes -

Sleeping patterns:

General health:

HEALTH DETAILS

Breathing problems	☐ YES	☐ NO	Psychiatric problems	☐ YES	☐ NO
Heart problems	☐ YES	☐ NO	Cancer	☐ YES	☐ NO
Blood pressure problems	☐ YES	☐ NO			

Details:

Pregnant	☐ YES	☐ NO	Sensitivity to cold, heat or pressure	☐ YES	☐ NO
Stress/anxiety	☐ YES	☐ NO	Allergies	☐ YES	☐ NO

Details:

Under current care of a:

Doctor	☐ YES	☐ NO	Chiropractor	☐ YES	☐ NO
Physiotherapist	☐ YES	☐ NO	_____	☐ YES	☐ NO

Details:

Headache	☐ YES	☐ NO	Varicose veins	☐ YES	☐ NO
Aches and pains	☐ YES	☐ NO	Numbness, tingling, pins-and-needles	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO	Blood clots	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO			
Epilepsy	☐ YES	☐ NO			

Details:

Bruise easily	☐ YES	☐ NO	Skin disorders	☐ YES	☐ NO
Contact lenses	☐ YES	☐ NO	Any other medical conditions	☐ YES	☐ NO

Details:

Medication:

Aspirin	☐ YES	☐ NO	Pain	☐ YES	☐ NO
NSAID	☐ YES	☐ NO	Blood thinners	☐ YES	☐ NO
Antibiotics	☐ YES	☐ NO	_____	☐ YES	☐ NO

Details:

PRESENTING CONDITION DETAILS

RECOMMENDATION

Signature: Date:

TREATMENT

Date: Reason for massage:

Active/Passive ROM:

Treatment:

Recommendations:

Date: Reason for massage:

Active/Passive ROM:

Treatment:

Recommendations:

Date: Reason for massage:

Active/Passive ROM:

Treatment:

Recommendations: