Arlington Massage
Therapy and Wellness

CLIENT HEALTH INFORMATION FORM

NAME: _____ **DATE:** _____

Prescribing Dr: _____Phone:_____

Primary Injury/Chief Complaint: _____

How did your symptoms start? _____

Date your symptoms/injury started._____ If symptoms were gradual, please choose a date symptoms prompted you to seek treatment.

Prior to this onset, were you free of these symptoms? YES ☐ NO ☐

Explain:_____

On a scale of from 1-10, please rate your average pain levels.

Pain intensity today	1 No Pain	2	3	4	5 Moderate Pain	6	7	8	9 10 Worst Pain
Average Pain (for the week)	1 No Pain	2	3	4	5 Moderate Pain	6	7	8	9 10 Worst Pain
Sleeping	1 Perfect Sleep	2	3	4	5 Disturbed Sleep	6	7	8	9 10 No Sleep
Work	1 Can do usual work	2	3	4	5 Can do 50% of work	6	7	8	9 10 Cannot Work
Level of Pain Medication	1 No Meds	2	3	4	5 Meds as Needed	6	7	8	9 10 Pain Meds Daily
Range Of Motion	1 Full Range of Motion	2	3	4	5 50% Range of Motion	6	7	8	9 10 Restricted Range
Sitting/Driving	1 No Pain	2	3	4	5 Pain Sitting after awhile	6	7	8	9 10 Pain with all Sitting
Standing	1 No Pain Standing	2	3	4	5 Pain Standing after a while	6	7	8	9 10 Pain with Standing

Please describe your pain. Check all that apply.

☐ Stabbing/Sharp ☐ Radiating ☐ Dull Ache ☐ Deep Ache
☐ Stiffness ☐ Weakness ☐ Nagging ☐ Burning
☐ Throbbing ☐ Cramping

Are you experiencing headaches? YES ☐ NO ☐ Average # of headaches per week?_____

Do you have any numbness/tingling? YES ☐ NO ☐ Where?_____

Effect of symptoms on daily activities. What could you do before that you can't do now?

_____

Have you had any previous or current treatment for this problem? YES □ NO □

Who did you see? _____ Did it help? YES □ NO □

What eases the pain? _____

What aggravates the pain? _____

Do you feel you are getting better_____ worse_____ or staying the same _____.

Are you taking medication? YES □ NO □ Please list_____

Have you had x-rays? YES □ NO □ Findings: _____

Have you had an MRI? YES □ NO □ Findings:_____

Please check if you have had any of the following conditions or illnesses.

□ Heart Murmur	□Hay Fever	□ Stroke	□ Asthma	□ Mental Illness	□ Tuberculosis
□ Depression	□ Emphysema	□ Angina	□ Cancer	□ Bronchitis	□ Rheumatic fever
□ Heart attack	□ Alcoholism	□ Diabetes	□ Anemia	□ Heart Disorder	□ Migraines
□ Thyroid Disease	□ Colon Disorder	□ Jaundice	□ Arthritis	□ Positive HIV test	□ High Blood Pressure
□ Kidney disease	□ Epilepsy	□ Hepatitis	□ Allergies	□ Skin Condition	□ Bleeding Disorder

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Are you allergic to any lotions, oils or scents?_____

Are you pregnant? YES □ NO □ How many weeks?_____

Massage will worsen any cold or flu-like symptoms and it is advised if you are sick to call and reschedule your appointment when you are feeling better.

Consent for Care/Benefit Assignment/Release of Information: I hereby authorize my insurance benefits to be paid directly to Arlington Massage Therapy &Wellness, I also authorize AMTW to release any information necessary, including medical records, chart notes, reports and billing statements to healthcare providers, insurance and attorneys for the purpose of processing claims.

CLIENT/GUARDIAN SIGNATURE:_____DATE:_____