Manual Therapist

WELLNESS CHART-F

Name _____ ID#/DOB _____ Date _____

Phone _____ Address _____

1. What are your goals for massage? _____

2. List typical daily activities—work, exercise, home. _____

3. Are you currently experiencing any of the following? If yes, please explain.

pain, tenderness	☐ No	☐ Yes: _____	stiffness	☐ No	☐ Yes: _____
numbness or tingling	☐ No	☐ Yes: _____	swelling	☐ No	☐ Yes: _____
allergies	☐ No	☐ Yes: _____			

4. List all illnesses, injuries, and health concerns you have now or have had in the past 3 years. (Examples: arthritis, diabetes, car crash, pregnancy) _____

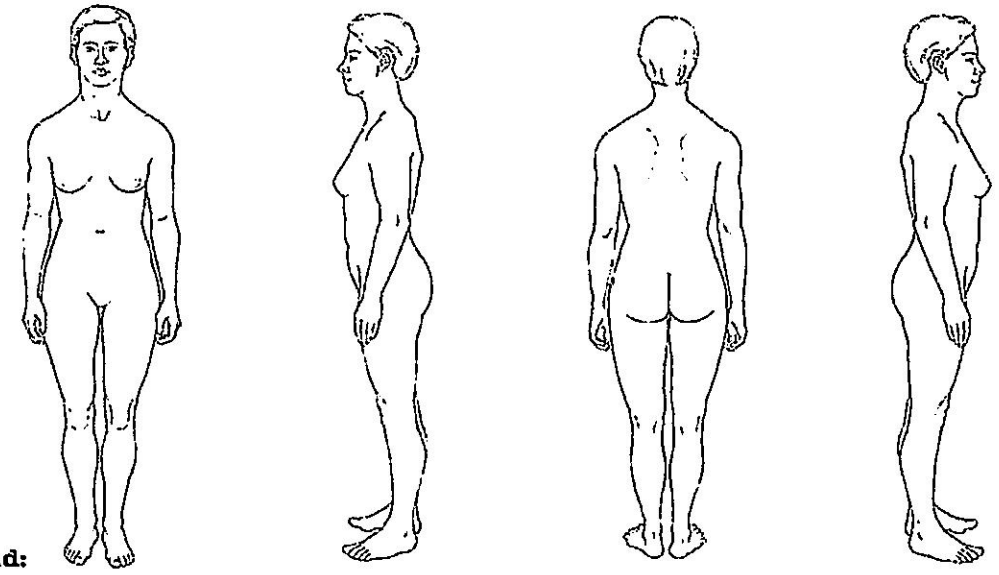
5. List medications and pain relievers taken this week. _____

6. I have provided all my known medical information. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

Signature _____ Date _____

Tx: _____

C: _____



Legend:

TP	TeP	Ⓟ	Infl	HT	SP	initials _____
Adh	Numb	rot	elev	Short	Long	

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