MUSCULOSKELETAL

Condition — Where?/When

Current Previous

- ☐ ☐ joint sprain_____
- ☐ ☐ muscle strain_____
- ☐ ☐ fracture_____
- ☐ ☐ dislocation_____
- ☐ ☐ whiplash_____
- ☐ ☐ low back pain_____
- ☐ ☐ scoliosis_____
- ☐ ☐ bursitis_____
- ☐ ☐ tendinitis_____
- ☐ ☐ carpal tunnel syndrome
- ☐ ☐ frozen shoulder_____
- ☐ ☐ flat feet_____
- ☐ ☐ sciatica_____
- ☐ ☐ arthritis (type_____)
  - -where_____
  - -Dr. diagnosed? yes/no
- ☐ ☐ other_____

INJURY & SURGERY ie: motor vehicle accidents, falls, work & sport related injuries

(Please include all injuries and surgeries, even those you may feel are not relevant)

type:_____
date:_____
current symptoms:_____

type:_____
date:_____
current symptoms:_____

type:_____
date:_____
current symptoms:_____

type:_____
date:_____
current symptoms:_____

type:_____
date:_____
current symptoms:_____

type:_____
date:_____
current symptoms:_____

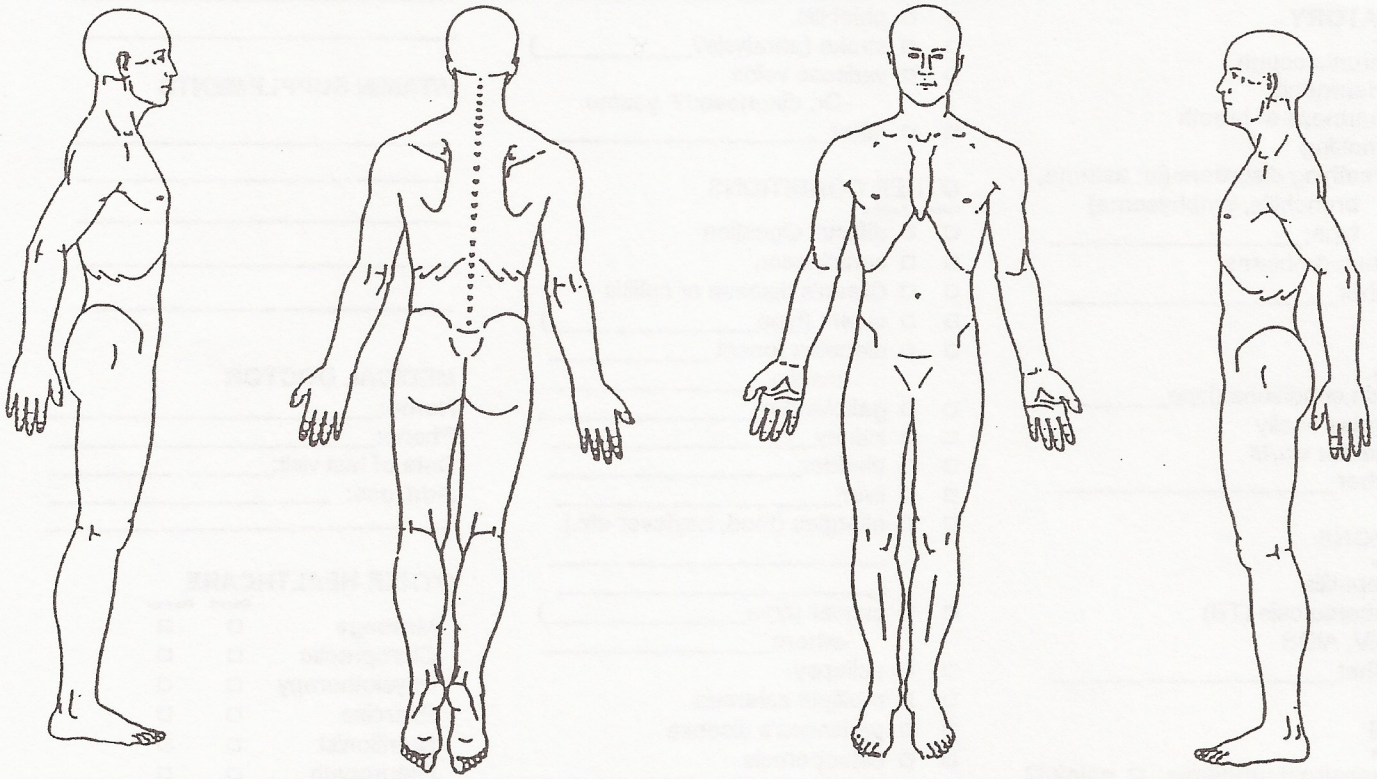
PAIN/STIFFNESS

Current Previous

- ☐ ☐ jaw
- ☐ ☐ neck
- ☐ ☐ shoulder L/R
- ☐ ☐ upper back
- ☐ ☐ mid-back
- ☐ ☐ lower-back
- ☐ ☐ elbow L/R
- ☐ ☐ wrist L/R
- ☐ ☐ hip L/R
- ☐ ☐ thigh L/R
- ☐ ☐ knee L/R
- ☐ ☐ leg L/R
- ☐ ☐ ankle L/R

Therapist comments:

ON THE DIAGRAMS BELOW, PLEASE INDICATE WITH A "X", ANY AREAS OF PAIN OR DISCOMFORT YOU ARE EXPERIENCING.



I understand that the information that I give on this form will be confidential and will be used for no other purpose than the professionial therapist's records. I understand that there is a 24 hour cancellation notice otherwise a missed appointment fee of $45.00 will be charged. If I was referred for Massage Therapy by another Health Care Professional, I hereby authorize my Registered Massage Therapist to discuss information regarding my records with that Health Care Professional.

Signature:_____ Date:_____