

# Patient History

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

Intern: \_\_\_\_\_ Class: \_\_\_\_\_ Term: \_\_\_\_\_

## Review intake questionnaire ('Cl's' or 'red flags'?)

- Why are they seeking massage therapy?

## Chief concern

### 1. Location/radiation

- Where does it hurt? (point to it)
- Does the pain move anywhere? if so where?

### 2. Onset (when/how)

- When did it start? (gradual or sudden)
- What is the cause of chief concern?
- What was the mechanism of injury?

### 3. Chronology/timing/prior episodes

- Have they had anything like this before?
- Clarify: Constant? Episodic? Occasional?
- How many times a day/week/month?

### 4. Quality (sharp, dull, shooting)

- Describe the pain with a word or two?
- Is it getting worse or better?

### 5. Severity (0-10)/effect on ADLs

- On a scale of 0-10 rate your pain (10 being the worst pain imaginable)?
- What is it at its worst? at its best?
- Does it affect any of your daily activities? (be specific)

### 6. Modifying factors (better/worse)

- What makes it feel better?
- What makes it feel worse?

### 7. Associated symptoms (NTW)

- Do they have any numbness, tingling or weakness?
- Any other symptoms associated with chief concern?

### 8. Treatment history/relevant prior injuries

- Have they seen anyone else about chief concern?
- If yes, then who (specific) & what treatment were given? Did they work?
- Any relevant prior injuries (when/treatment given)?

### 9. Medications (purpose, dose, frequency, last dose)

### 10. Allergies

## Conditional factors

### 1. Hereditary conditions/family health issues

- Do any conditions run in family?

### 2. Stress factors

- What are their main life stress factors?

### 3. Exercise/interests (activities/frequency)

### 4. Diet (rate: good, fair, poor)

### 5. Sleep pattern (wake rested)

### 6. Habits (alcohol, tobacco, recreational drugs)

### 7. Treatment goal (this treatment & long term)

"Anything else they would like to add?"