Massage Therapy Connections
Promoting Wellness • Relieving Pain

Clinical Interview for Medical Massage

Name: _____ **Date**: _____

General Questions

1. Primary complaint:

2. How long have you had symptom(s)?

3. What symptoms do you have right now (at the moment of interview)?

4. When and how did everything start?

5. Have you seen anyone especially your physician and has any diagnosis already been established? Were any tests
   (x-ray, MRI, CT Scan, nerve conducting study, etc.) done?

6. What treatments, if any, were used?

7. Do any family members have similar problems?

8. Were other health conditions or medications eliminated by the primary physician as potential causes of the patient's symptoms?

9. Have you experienced any previous traumas?

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Pain Evaluation

1. How would you describe the pain you have or had?

□ sharp □ aching □ burning □ pulsating

2. If pain felt in one location or does it radiate to other parts of the body?
□ local radiation □ distant radiation

3. Did you notice if the pain you have is accompanied by:

□ headache
□ nausea
□ sweating
□ "goose bumps"
□ changes in the body's temperature

4. Did you have the sensation that the original pain triggers pain in other parts of your body?

□ Yes □ No

If yes, where? _____

5. Do you feel pain when you wake up in the morning?

□ Yes □ No

6. Do you feel the pain is getting worse by late afternoon/evening?

□ Yes □ No

7. Do you have night pain?

□ Yes □ No

8. Do you have difficulties falling asleep or wake up during the night due to pain?

□ Yes □ No

9. How is the pain you feel affected by your movement?

□ Movements increase pain intensity
□ Movements decrease pain intensity
□ Movements have no effect on the pain intensity

10. How do you grade your pain intensity on a 1-to-10 grade scale?

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Evaluation of Sensory and Motor Abnormalities

1. Have you had in the past or do you currently have sensations of tingling or numbness in any parts of the body?

   □ Yes □ No

   If yes, where? _____

2. Do you feel any restriction in your range of motion?

   □ Yes □ No

   If yes, where? _____

3. Do you feel any muscle weakness?

   □ Yes □ No

   If yes, where? _____

Additional Notes

Therapist: _____