Massage Therapy Connections
Promoting Wellness • Relieving Pain

Name: ______________________________

Date: ______________________________

Use the “Additional Notes” on page 3 for any details you’d like to add.

Intake for Medical Massage or Neuromuscular Therapy

General Questions

1. Primary complaint:

2. How long have you had symptoms?

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 heath conditions or medications eliminated by the primary physician as potential causes of your symptoms?

9. Have you experienced any previous traumas?

Pain Evaluation

How would you describe the pain you have or had?

☐ Sharp ☐ Aching ☐ Burning ☐ Pulsating

Is pain felt in one location or does it radiate to other parts of the body?

☐ local radiation ☐ distant radiation

Have you noticed if the pain you have is accompanied by:

☐ Headache
☐ Nausea
☐ Sweating
☐ "Goose bumps"
☐ Changes in the body's temperature

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

☐ Yes ☐ No

If yes, where? ______________________________________

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Do you have night pain?

☐ Yes ☐ No

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

☐ Yes ☐ No

How is the pain you feel affected by your movement?

☐ Movements increase pain intensity
☐ Movements decrease pain intensity
☐ Movements have no effect on pain intensity

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

Evaluation of Sensory and Motor Abnormalities

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

☐ Yes ☐ No

If yes, where? ____

Do you feel any restriction in your range of motion?

☐ Yes ☐ No

If yes, where? ____

Do you feel any muscle weakness?

☐ Yes ☐ No

If yes, where? ____

Additional Notes