# ALASKA MASSAGE CLINIC

Therapeutic & Medical Massage

# Progress Exam Intake

## PATIENT INFORMATION

Legal Last Name | Legal First | DOB:

## HEALTH HISTORY

Please list all current medications (OTC/Prescription/Vitamins):

Please list allergies:

Are you pregnant? ❑ Yes ❑ No   If yes, how far along are you?

**History** Please check conditions or symptoms you currently have or have had in the past:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | HIV/AIDS | ☐ | Poor Circulation | ☐ | Epilepsy | ☐ | Arthritis | ☐ | Rheumatic Fever | ☐ | Numbness |
| ☐ | Nerve Damage | ☐ | Hepatitis | ☐ | Ulcers | ☐ | Heart Disease | ☐ | Diabetes | ☐ | Migraines |
| ☐ | Jaw Pain/TMJ | ☐ | Multiple Sclerosis | ☐ | Gout | ☐ | Pace Maker | ☐ | Polio | ☐ | Tendonitis |
| ☐ | Whiplash | ☐ | Varicose Veins | ☐ | Malaria | ☐ | Tumors | ☐ | Osteoporosis | ☐ | Typhoid Fever |
| ☐ | Cancer | ☐ | Blood Clots | ☐ | Measles | ☐ | Stroke | ☐ | Scoliosis | ☐ | Tuberculosis |

**Operations** Surgical interventions, which may or may not have included hospitalization:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | Cancer | ☐ | Bypass Surgery | ☐ | Appendix | ☐ | Hip Surgery | ☐ | Hysterectomy | ☐ | Arm/Wrist |
| ☐ | Spinal Surgery | ☐ | Shoulder Surgery | ☐ | Knee Surgery | ☐ | Neck Surgery | ☐ | Cosmetic, what specifically: | | |
| ☐ | Other: | | | | | | | | | | |

**Family History** Are there any hereditary issues that you would like us to know about or that may be affecting your current concern?

**Social History** Please indicate below regarding your health habits:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Alcohol Use | ○ Daily | ○ Weekly | How much: ______________ | Exercising | ○ Daily | ○ Weekly | How much: _____________ |
| Caffeine Use | ○ Daily | ○ Weekly | How much: ______________ | Pain Relievers | ○ Daily | ○ Weekly | How much: _____________ |
| Tobacco Use | ○ Daily | ○ Weekly | How much: ______________ | Water Intake | ○ Daily, on average, how many ounces: ___________ | | |

## CONDITION HISTORY

Have you experienced any recent trauma? (MVA, falls, etc)
❑ No ❑ Yes, please explain:

The symptom(s) that prompted you to seek care today are:

Pain Scale (10 being the worst)
0 1 2 3 4 5 6 7 8 9 10

Are you seeking treatment elsewhere for this? If so, where:

**Onset** When did you first notice your current symptoms?

**Radiating** Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?

**Aggravating or relieving factors** What makes it better or worse, such as time of day, movements, certain activities etc.?

**Worse**: 

**Better**:

**Prior Interventions** Have you done anything to relieve the symptoms? ○ prescription meds ○ over-the-counter meds ○ homeopathic remedies ○ physical therapy ○ chiropractic ○ surgery ○ acupuncture ○ massage ○ ice ○ heat

What else should your provider know about your current condition?