Spartanburg Regional Healthcare System

CENTER FOR INTEGRATIVE MEDICINE: MASSAGE THERAPY

Thank you for choosing Spartanburg Regional Healthcare System for your healthcare needs.

Name: _____ **Date:** ____ / ____ / _____ **Sex:** ____

Employer: _____ **Type of Work:** _____

Daily Activities: [ ] Sitting [ ] Standing [ ] Walking [ ] Lifting [ ] Bending [ ] Driving / Riding

Medical Conditions: [ ] Blood Clots [ ] Cancer [ ] Diabetes [ ] Fibromyalgia [ ] Heart Problems

[ ] High Blood Pressure [ ] Low Blood Pressure [ ] Pregnancy [ ] Varicose Veins

[ ] Other: _____

Recent Surgery: _____ **Date:** ____ / ____ / _____

Recent Injury: _____ **Date:** ____ / ____ / _____

Traffic Accident/Collision: _____ **Date:** ____ / ____ / _____

Current Medications: _____

_____

What problems have brought you in, today? _____

_____

Do you have restricted range of motion? [ ] Arms [ ] Back [ ] Legs [ ] Neck

Are you having any of the following? [ ] Numbness [ ] Pain [ ] Tightness [ ] Tingling

[If so] **Where?** _____

Have you ever had a massage before? [ ] Yes [ ] No

[If so] **How long ago?** _____

Do you want your massage to be: [ ] Relaxing [ ] Therapeutic [ ] Combination (per therapist findings)

Do you prefer pressure to be: [ ] Very Light [ ] Light [ ] Medium [ ] Deep [ ] Very Deep

Signature: _____ **Date:** ____ / ____ / _____