

UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS
 Massage Therapy Program
Health History Questionnaire

NAME
 REG. NO.
 BIRTHDATE

Instructions: Please fill out all applicable information and call (734) 232-5029 for an appointment. If you are a UMHS registered patient, please also fill out the upper right hand corner.

Please identify yourself (check one):

- Hospitalized Patient (Inpatient)** **Client registered in UMHS (Non-hospitalized)**
 Other: First Name: _____ Last Name: _____ Birthdate: ____/____/____

For current hospitalized patients, please include the following:

UMHS Department/Hospital Room#: _____ Family Contact Phone#: (____) _____

Type of massage requested: Chair Table/Bedside
 Length of massage (minutes): 15 20 30 45 60

Your occupation/duties: _____

What are your expectations of the massage therapy treatment?

- Relaxation Pain relief Stress reduction
 Other (specify): _____

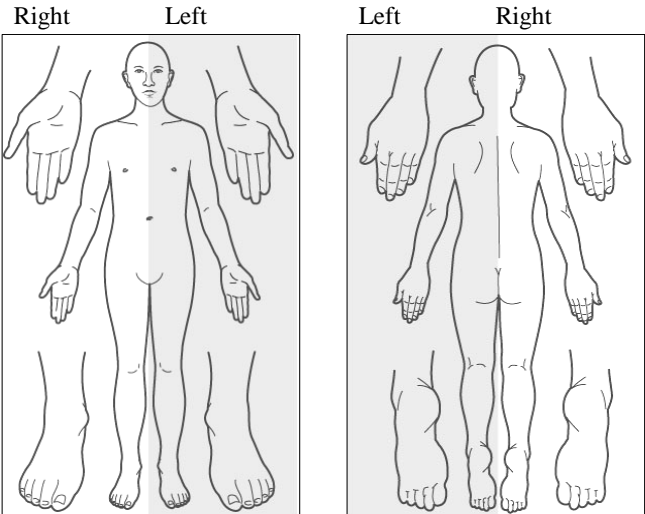
Have you ever had massage therapy or bodywork before?

- No Yes, if yes, when? _____

Please list and explain current medications, recent injuries, painful areas, broken bones, serious or chronic illness, surgeries, or traumatic accidents:

- See Inpatient Record

Circle areas you would like worked on (areas to massage)



Are you currently taking any anti coagulants or blood thinners like Aspirin, Motrin, Heparin, Lovenox or Coumadin (Warfarin)?

- No Yes, if yes, which? _____

Are you currently on chemotherapy? No Yes _____

Please check off any of the following conditions or symptoms which apply to you now or in the past:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Nut allergy or other allergy	<input type="checkbox"/> High or Low Blood Pressure	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Fractures	<input type="checkbox"/> Heart Attack or Stroke	<input type="checkbox"/> Hypo or Hyperglycemia	<input type="checkbox"/> IV site, central line or port Location: _____
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Other Heart condition	<input type="checkbox"/> Muscle Sprain/Strain	<input type="checkbox"/> Blood Clots or DVT <input type="checkbox"/> Chronic (Old) Treatment: _____ <input type="checkbox"/> Acute (New) Treatment: _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Spasms/Cramps	<input type="checkbox"/> Athlete's foot	
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Spinal Problems	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Tendonitis	<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Currently Pregnant	
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Swelling or edema	<input type="checkbox"/> Skin Infections/ Rashes	
<input type="checkbox"/> Open Sores	<input type="checkbox"/> Herpes/Shingles	<input type="checkbox"/> Varicose Veins	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Headache/Migraine	<input type="checkbox"/> Bone or Joint Disease	
<input type="checkbox"/> Numbness	<input type="checkbox"/> Constipation/Diarrhea	<input type="checkbox"/> Other conditions (specify): _____	

* Please list and explain "other conditions" or symptoms you are experiencing or have experienced: _____

The patient/client may request a copy of this document for their health records

- No I do not want a copy
 Yes, Please mail a copy to: _____ City: _____ State: _____ Zip: _____

Signature of Patient/Client or Legally Authorized Representative (if patient/client is a minor or unable to sign) _____ Date(mm/dd/yy) _____

Questionnaire Obtained by (Massage Therapist Name): _____ Signature _____ Date(mm/dd/yy) _____ Time _____ A.M./P.M.