



MASSAGE THERAPY CONSULTATION FORM

IO MEDICAL AESTHETICS CLINIC

Name: _____ Date of Birth: _____

Have you ever received a massage before? **Yes** **No**
What is your major complaint? _____
How did this happen? _____

When did this problem start? _____

My pain is: **Increasing** **Consistent** **Intermittent**
How long does the pain last: _____

On a scale from 1-5 (1 – moderate 5 - severe) how would you rate the pain?
1 2 3 4 5 (Please circle one)

When do you feel the most discomfort? _____

Please indicate the location of your pain:

Muscles

- Neck
- Low-back
- Mid-back
- Upper back
- Shoulders
- Leg: left/right
- Knee: left/right



Please describe the discomfort:

- Sharp
- Dull
- Throbbing
- Burning
- Shooting
- Tightness
- Aching
- Tingling
- Numbness
- Weakness
- Other

Please indicate the activities that relieve the discomfort:

- Rest
- Heat
- Activity
- Ice
- Medication: _____
- Therapy: _____
- Other: _____

- Coughing
- Activity: _____
- Bending
- Standing
- Driving
- Sitting
- Lifting
- Other: _____

Please indicate the activities that aggravate the discomfort:

I certify that all of the above information is accurate and correct:

Patient Signature: _____ Date: _____