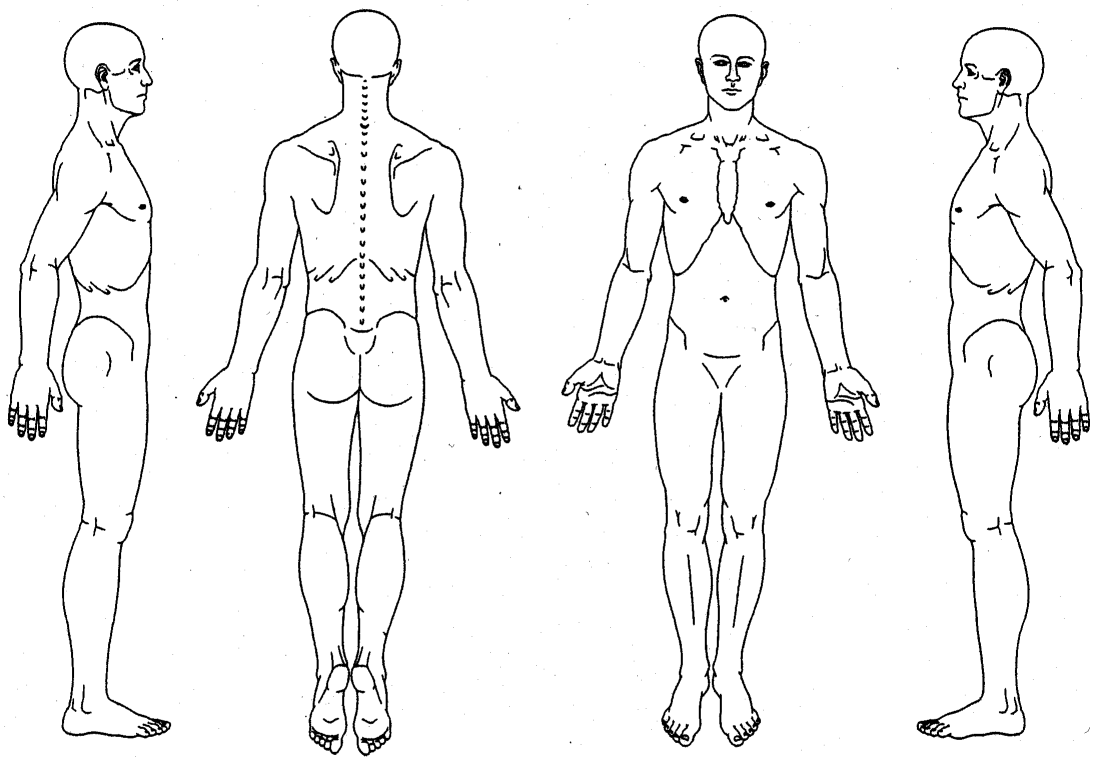
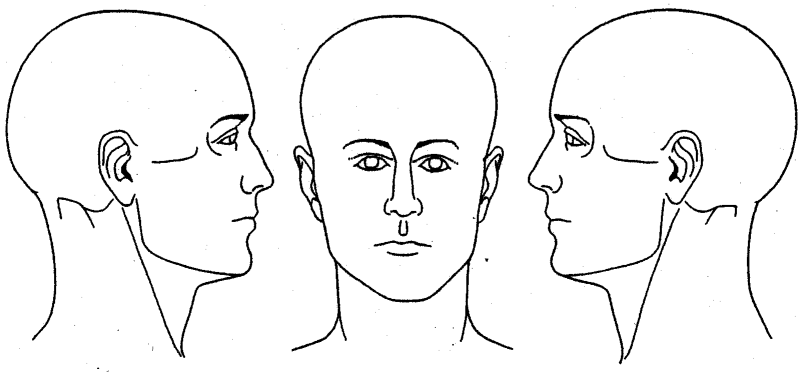
PAIN RECORD

NAME **AGE** **SEX** **DATE**

MAJOR PROBLEM TODAY:

WITH RED PENCIL, COLOR THE AREAS WHERE YOU'VE HAD PAIN LATELY:





CTB Intake Form -- Thai Bodywork School of Thai Massage

When filling out online, please use **bolded** type as this makes it easier to read. Thank you!

Name:_____ Age:_____ Birth Date:_____

Address: _____ City:_____ Zipcode:_____

Home Phone:_____ Work/Cell: _____

Email: _____

Emergency Contact: _____ Phone:_____

Referred By: _____

Medical History:

Height :_____ Weight: _____
Are you currently under the care of a physician? ___Yes___No
If yes, what for? _____
Are you currently under the care of an alternative medicine practitioner? Yes/No
If yes, what for? _____
Are you currently under the care of a chiropractor? ___Yes___No
If yes, what for? _____

Please check any of the following that apply to you (in the past or currently):

___ Heart problems	___ Arthritis	___ Back problems
___ High blood pressure	___ Osteoarthritis	___ Spinal problems
___ Blood clots	___ Wear contact lenses	___ Disc problems
___ Varicose veins	___ Pregnant	___ Joint problems
___ Pacemaker	___ Diabetes	___ Accidents or Injuries
___ Neurological problems	___ Surgery	___ Major illness or disease
___ Headaches	___ Epilepsy or Seizures	___ Recent breaks/sprains
___ Sinus problems	___ Digestive problems	___ Skin problems
___ Circulatory problems	___ Constipation	___ Respiratory problems

Has your physician told you that you have any of the following?
__Herniated/bulging disks __Spinal Stenosis __Scoliosis __Diabetes __Thyroid Problem

Do you use any other body therapies?
___Chiropractic ___Massage ___Physical Therapy ___Acupuncture ___Tens Unit
Other: _____
What do/did you use the therapy for? _____

How much water do you drink per day?

_____
List any food sensitivities:

_____
Do you wear orthotics? ___Yes ___No How long have you worn them?

_____

Do you, or did you as a child prefer to sit on one leg? ___Yes ___No

Medications:

List any medication you currently take:

_____

List any medication you have used in the past and why you stopped taking it:

_____

List any vitamins, minerals, supplements that you take:

_____

Pain History:

Describe any pain/tension. How long have you had it?

_____

_____

_____

Was there an event or illness that seemed to start it?

_____

Is your pain/tension worse in the morning or evening?

_____

Does anything seem to change your pain? Make it worse/better?

_____

Are there particular movements associated with your pain?

_____

Please list any accidents, surgeries, etc. starting with the most recent.

Date/Accident

_____

_____

_____

Jaw/Facial Pain:

Do you have TMJ? ___Yes ___No

Do you have jaw pain associated with chewing or yawning? ___Yes ___No

Do you clench or grind your teeth? ___Yes ___No

Do you wear a night guard? ___Yes ___No

When was your last dental appointment? _____

Do you wear bifocals or progressive lenses? ___Yes ___No

Do you or have you ever experienced any visual disturbances? ___Yes ___No

If yes, please explain?_____

When was your last eye doctor appointment? _____

Life/General:
Rate the level of stress in your life as you perceive it:
___High ___Medium-High ___Medium ___Medium-Low ___Low

What are your goals regarding your overall quality of life?

1. _____
2. _____
3. _____
4. _____

Home Stress:
Do you have child-care or other home-tasks? ___Yes ___No
Are you immobile for long periods of time? ___Yes ___No
Do you lie on the couch or bed and read? ___Yes ___No

Work Stress:
Are you able to work? ___Yes ___No

_____
How do you feel after a day of work?

_____
Does your pain affect your work?

_____
What is your occupation?

_____
Do you perform repetitive movements at work?

_____
Are you immobile for long periods of time?

_____
Given the opportunity, what would you like to do?

_____

Activities/Hobbies:
List any activities/hobbies you do on a regular basis? (musical, sport, sewing, gardening, etc.) and how frequently you do them:

_____

_____

_____

Excercise:
Are you able to exercise? ___Yes ___No
What types of exercise do you do and how frequently?

_____

What type of exercise do you think you would enjoy doing?

_____

Do you stretch regularly? ___Yes _____No

If yes, what stretches, when?_____

Sleep:

How many hours of sleep do you typically get? _____

Do you experience any of the following?

___Difficulty Falling Asleep ___Waking Often ___Waking Unrefreshed

What position do you sleep in?

___Back ___Side ___Stomach ___Arms Overhead

___Half-Stomach/Half-Side ___Fetal Position ___Spooning ___With Pets

If you sleep on your back, do you put pillows under your knees? ___Yes ___No

If you sleep on your side, do you put pillows between your legs? ___Yes ___No

At your chest? ___Yes ___No

Alcohol/Tobacco/Caffeine/Sugar:

Do you drink alcohol? ___Yes ___No

What kind and how often?

_____

Do you smoke or use tobacco products? ___Yes ___No

What kind and how often?

_____

Do you drink caffeinated beverages? ___Yes ___No

What kind and how often?

_____

Do you drink juice? ___Yes ___No

What kind and how often?

_____

Do you frequently eat foods with high amounts of sugars/carbohydrates? ___Yes ___No

What kind and how often?

_____

Consent for Thai Bodywork Treatment

I understand that the purpose of Thai Bodywork is for relaxation and that it is not meant to diagnose or treat any illness, disease or any other physical or mental disorder, injury or condition. I have informed my Thai Bodywork practitioner about my state of health and any recommendations and restrictions on the part of my medical doctor or therapist insofar as bodywork is concerned. I understand that if I cancel a session less than 24 hours in advance I will be billed for the session.

Client Signature

X _____ Date: _____

Consent for Participation in the Thai Bodywork CTB Practicum
By my signature below, I acknowledge that I have agreed to receive one or more massage therapy sessions from a student enrolled in classes at Thai Bodywork School of Thai Massage. I understand that the primary purpose of these sessions is to afford the student a learning opportunity to practice specific hands-on methods and related professional skills as part of their required course work in the program. As a client, I may reasonably expect to receive the general benefits of Thai massage such as relaxation, reduction in muscle tension and increase in range of motion.

I understand that it is necessary for the student and/or faculty supervisors to touch and observe my body in order to conduct this process. I give Thai Bodywork and the student full permission to work on my body in such a way. I acknowledge that I also have the right to decline treatment to any part of my body, and to request modifications to the session plan.

Client records are the property of Thai Bodywork and their confidentiality shall be maintained at all times. I understand that my health history and treatment-related information may be discussed between the student and faculty for educational purposes only, and that this information will not be shared outside of the teacher/student relationship.

Client Signature

X _____ Date:_____

Thank you for taking the time to complete this form.
We look forward to working with you on your journey to better health.