

## **Screening**

Your main tool for providing a safe service is your client's case/health history. A number of components should be included in a pre-screen form:

- Demographic information, such as age, sex and occupation
- Health risk factors
- Recent or current illness history
- Medication being taken
- Surgery and injury history
- Family and medical history

### **Reasons for the inclusion of the above factors in a health screen.**

Demographic information is required as gender, age, occupation and contact numbers provide the practitioner with valuable information. There may be some risks associated with the client's occupation that may need to be noted and enquired into. Information on health risk factors need to be noted and special needs recorded as they may require different attention and in some cases referral to a medical practitioner. Cardiovascular risk factors, medications and illness/injury information will all have an impact on the strokes used on the client. Read contraindications section. Listing common conditions that affect the client will help give a valuable insight into their medical history. Family history may provide insight into the client's condition. If the client is going to be attending you on a regular basis it is a good idea to update the health screen every once in a while or if a new condition arises.

A pre-screening form provides the practitioner with valuable information and protects them and the client.

The following is a case history form developed with the students on the Health & Leisure Course with Massage at the Institute of Technology in Tralee, Co Kerry during the academic year 2009/2010 and is a work in progress:

### **Case History Form**

**Section 1: Demographic Information**

Surname: \_\_\_\_\_ Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Home number: \_\_\_\_\_

Mobile: \_\_\_\_\_

Doctors name: \_\_\_\_\_

Doctor's Number: \_\_\_\_\_

Person to Contact in an Emergency: \_\_\_\_\_

Contact number: \_\_\_\_\_

\*\*Living Arrangements: Married/ single/ separated/ co-habiting

Children: \_\_\_\_\_

Friends & Family: \_\_\_\_\_

**Section 2: Lifestyle information**

What are your hobbies and interests: \_\_\_\_\_

What type of exercise do you engage in?

How often? \_\_\_\_\_

Do you sleep well? \_\_\_\_\_

How would you describe your diet? \_\_\_\_\_

On a scale of 1 to 10 with 1 being lowest and 10 highest, how would you rate your current levels of stress?

How do you manage stress? \_\_\_\_\_

What are your smoking patterns? \_\_\_\_\_

What are your drinking patterns? \_\_\_\_\_

**Section 3: Needs Assessment:**

Why have you come for massage? Or why are you here today? Present condition/illness

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**Other illnesses/imbbalances at present?**

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Have you had a massage before?  
How was massage of benefit in the past?

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**VISUAL DIAGNOSIS:**

**Past Medical History:**

**Family history:**

**Section 4: Health Overview:**

Lungs & respiratory system:

Skin:

Abdomen: Colon: Digestion:  
 Liver and Gall Bladder:  
 Heart/Circulation:  
 Extremities:  
 Endocrine System:  
 Nervous system:  
 Eyes:  
 Ears:  
 Nose:  
 Throat:  
 Immune System:  
 Allergies:  
 Genito – Urinary:

Please indicate if you suffer or have suffered from any of the following:

Epilepsy - referral	Yes [ ]	No [ ]
Asthma	Yes [ ]	No [ ]
Cancer - type and referral	Yes [ ]	No [ ]
Tumour, growth, cyst, cancer	Yes [ ]	No [ ]
Skin condition - depth, creams and treatment	Yes [ ]	No [ ]
Bruised Tissues	Yes [ ]	No [ ]
Scar tissue	Yes [ ]	No [ ]
Thrombosis - referral	Yes [ ]	No [ ]
Diabetes	Yes [ ]	No [ ]
Muscle, joint or back disorder	Yes [ ]	No [ ]
Treated broken bone	Yes [ ]	No [ ]
Pregnant or have been in past three months	Yes [ ]	No [ ]
Osteoporosis	Yes [ ]	No [ ]

### Section 5 - On the Day Clearance

This section is designed to ensure you have an enjoyable and relaxing massage.

1. Have you eaten a heavy meal in the last 3 hours?
2. Have you taken drugs or alcohol in the last 24 hours?
3. Have you had major surgery in the past 12 months or minor surgery in the past 6 months?
4. Do you have any injuries at present?
5. Have you a high temperature?
6. Any unexplained swelling or tenderness?
7. Are you on any medication?



TACTILE DIAGNOSIS:

PLANNED TREATMENT: (Include time guide)

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ACTUAL

TREATMENT:

GENERAL OBSERVATIONS and FOLLOW\_UP