QUEENSBOROUGH COMMUNITY COLLEGE | CUNY

Office of Health Services
Medical Arts Building, Room, MC-02
222-05 56th Avenue, Bayside, New York 11364-1497
Telephone (718) 631-6375 • Fax (718) 631-6330

Medical Record for Massage Therapy

Please submit **Two** copies and original of all material to Health Services. Health Services will **Not** make copies for you. Whiteout renders forms null and void.

– To be completed by Student –

Student Information (Please print):

CUNYFIRST ID No.: _____ Last four digits of S.S. No.: _____

Gender: Male _____ Female _____ Trans. (specify) _____ Other (specify) _____

Last Name: _____ First Name: _____ Birth Date: _____ /_____ /_____

Address: _____ City _____ State _____ Zip _____

E-mail: _____

Home Phone No.: _____-_____–_____ Cell No.: _____-_____–_____

Emergency Contact Information:

Last Name: _____ First Name: _____ Relationship: _____

Home Phone No.: _____-_____–_____ Cell No.: _____-_____–_____

Check any conditions that apply and if medications are taken for that condition.

Condition	Yes	Meds.	No	Condition	Yes	Meds.	No
Allergies	☐	☐	☐	Heart	☐	☐	☐
Asthma	☐	☐	☐	Injuries	☐	☐	☐
Cancer	☐	☐	☐	Kidney	☐	☐	☐
Seizures	☐	☐	☐	Musculoskeletal	☐	☐	☐
Diabetes	☐	☐	☐	Psychological	☐	☐	☐
Drug/ Alcohol Abuse	☐	☐	☐	High Blood Pressure	☐	☐	☐
Ears/Nose/Throat	☐	☐	☐	STDs/STIs	☐	☐	☐
Neurologic	☐	☐	☐	Thyroid	☐	☐	☐
Fainting	☐	☐	☐	Tuberculosis	☐	☐	☐
Gastro-intestinal	☐	☐	☐	Other	☐	☐	☐

Briefly describe any condition checked "yes" above and list subsequent medications: _____

_____

List any surgeries or conditions not mentioned above and list subsequent medications: _____

_____

Check any physical handicap and/or condition that applies.

Wheelchair bound ☐ Use of crutches or braces ☐ Neurologic impairment ☐ Speech Impediment ☐

Blind or Partially Sighted ☐ Deaf or Hard of Hearing ☐

Briefly describe any physical handicaps: _____

_____

Physical Examination

Please submit **Two** copies and original of all material to Health Services. Health Services will **Not** make copies for you. Whiteout renders forms null and void.

– To be completed by Health Practitioner (MD, DO, NP, or PA) –

Student Information (Please print):

Last Name: _____First Name: _____ Birth Date: _____ /_____ /_____

Last four digits of S.S. No.: _____

Blood Pressure: _____ Heart Rate: _____ Height: _____ Weight: _____

Vision OU: _____ Vision OD: _____ Vision OS: _____

Influenza Vaccination Date: _____ /_____ /_____ Lot #: _____ Expiration Date: _____

System	**Normal**	**Abnormal**	**Remarks** *(describe abnormalities)*
Head/Neck			
Eyes/Ears			
Integumentary			
Skeletal			
Muscular			
Digestive/ Abdomen			
Lymphatic			
Respiratory			
Endocrine			
Neurologic			
Circulatory/Cardiac			
Genitourinary			
Psychological/Emotional			

Is student able to perform massage therapy tasks? ☐ Yes ☐ No

If no, please describe why: _____

_____

Is there any psychological or emotional condition(s) for which student is being treated? ☐ Yes ☐ No

If yes, please describe: _____

Health Practitioner Name: _____ Title: _____ License No.: _____

Address: _____ City _____ State _____ Zip _____

Office Phone No.: _____-_____-_____ Fax No.: _____-_____-_____

Examination Date: _____ /_____ /_____

Health Practitioner Signature _____

Health Practitioner Stamp Required (MD, DO, NP, or PA)

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