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Patient Information

(Please print clearly)

Name ______________________ SS# ____________ Birthdate __________
(first) (middle initial) (last)

Address ______________________________

City ______________ State __________ Zip________

Home Phone (______) ______________ Cell Phone (______) ______________

Work Phone (______) ______________ Email ______________

PatientEmployer ______________________ Occupation ______________

Whom may we thank for referring you to us? ______________________

Person to contact in case of emergency ______________________

Relationship ______________ Phone (______) ______________

Insurance Information

Name of Insurance Co. ______________________

Claim # ______________________ Phone (______) ______________

Address of Insurance Co. ______________________

Name of Insured ______________ Birthdate __________ SS# ______________

Relationship to insured ______________ Insured's Employer ______________

Work Phone (______) ______________

Is this related to an accident or work related injury? ________ Explain ______________

____

If yes to the above: Date of Injury ____________ Have you retained an Attorney? __________

Name of Attorney ______________________ Phone (______) ______________

Health/Massage History

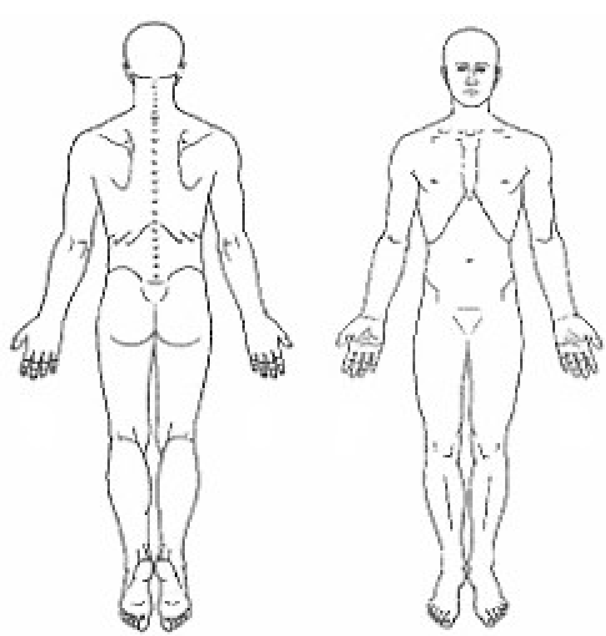
Have you ever received professional massage before? ________ Date of last massage ______________

On the figures to the right indicate the areas in which you are experiencing symptoms that need addressed. (ie, Pain, Soreness, Tightness, Tension)

What results would you like from your massage therapy session?

____

____



____
____
____

List stress reduction and exercise activities, including frequency______________________________
____
____

List current medications, including aspirin, ibuprofen, etc.___________________________________
____
____

Previous History____

(include year and treatment received)

Surgeries____
____

Accidents/traumas, including motor vehicle accidents, falls, etc. ___________________________
____

Nervous System: (circle all that apply)

Numbness/tingling	fatigue	herpes/shingles
Chronic pain	sleep disorders/disturbances	other_____________________

Musculoskeletal: (circle all that apply)

Bone/joint disease	arthritis	headaches/head injuries
Tendonitis	sprains/strains	cramps/spasms
Bursitis	low back, hip, leg pain	lupus
Broken/fractured bones	neck, shoulder, arm pain	other_____________________

Circulatory: (circle all that apply)

Heart conditions	high blood pressure	difficulty breathing
Varicose veins	low blood pressure	sinus problems
Blood clots	lymph edema	other_____________________

Infectious: (circle all that apply)

Disease name__________________	Rashes	warts
Allergies_______________________	Athlete's foot other____________________________	

Digestive: (circle all that apply)

Constipation	diverticulitis	gas/bloating
Irritable bowel syndrome	other____________________________	

Reproductive: (circle all that apply)

Pregnant?______weeks_________ PMS other____________________________

Other

Cancer/tumors	diabetes	eating disorders

Depression drug/alcohol addiction nicotine/caffeine addiction

Signature____ Date___________________