

MASSAGE THERAPY REGISTRATION AND HISTORY

1 CLIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Client _____

Insurance Co. _____

Group # _____

Is client covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Client _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____ Cell (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home (_____) _____ Work (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5 CLIENT CONDITION

When did your symptoms appear? _____

What treatment have you already received for your condition?
 Medication Surgery Physical Therapy Chiropractic Care None Other

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

Name and address of doctor(s) or other healthcare practitioner(s) who have treated you for your condition:

Name _____ Name _____
Address _____ Address _____
Phone (_____) _____ Phone (_____) _____

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MESSAGE HISTORY

Have you ever received a professional massage? Yes No

Why did you come for our service? Relaxation Pain Therapy Other _____

What results would you like to achieve? _____

Prioritize the areas of your body that you wish to be massaged. Please note any areas of your body that you **prefer not to be massaged**. _____

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HEALTH HISTORY

Please check conditions or symptoms you currently have or have had in the past:

- | | | | | |
|-----------------------------------------------|----------------------------------------------|----------------------------------------------|-----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Herpes | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Fractures | <input type="checkbox"/> Jaw Pain/TMJ | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |

MEDICATIONS

Medication	Taking For
_____	_____
_____	_____

ALLERGIES

VITAMINS/HERBS/MINERALS

EXERCISE

- None Daily
- Moderate Heavy

WORK ACTIVITY

- Sitting Light Labor
- Standing Heavy Labor

LIFESTYLE

- Smoking Packs/Day _____ Coffee/Caffeine Cups/Day _____
- Alcohol Drinks/Week _____ High Stress Level Reason _____

Are you pregnant? Yes No Due Date _____

Please list any medical conditions, surgeries, accidents, and bone, joint, nerve or muscle diseases or injuries not specified above.

_____ Date _____ Date _____

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AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my health care provider if I ever have a change in health.

I understand that massage therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis or treatment by a physician. I understand that individuals providing massage therapy services are not qualified to diagnose, prescribe or treat any physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from individuals performing massage therapy services is educational in nature and is to be used at my own discretion.

_____ Date _____

Signature of Patient, Parent, Guardian or Personal Representative

Date

_____ Relationship to Patient _____

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient