HEALTH INFORMATION

Patient Name: ______________________________ Date: ____________

Date of Injury: ______________ Date of Birth: ______________________

[PATIENT INFORMATION]

Address: ______________________

City: __________ State: ____ Zip: ______

Phone: Home: ______________________

Cell: __________ Work: __________

Employer: ______________________

Work Address: ______________________

Occupation: ______________________

Emergency Contact: ______________________

Phone: Home: ______________________

Cell: __________ Work: __________

Primary Health Care Provider: ______________

Name: ______________________

Address: ______________________

City: __________ State: ______ Zip:

Phone: __________ Fax: __________

I give my massage therapist permission to consult with my health care providers regarding my health and treatment.

Initials: __________ Date: __________

[CURRENT HEALTH INFORMATION]

List health concerns – check all that apply.

Primary: ______________________

○mild ○moderate ○disabling

○constant ○intermittant

○symptoms ↑w/activity ○symptoms ↓w/activity

○getting worse ○getting better ○no change

Treatment received: ______________________

____

Additional: ______________________

○mild ○moderate ○disabling

○constant ○intermittant

○symptoms ↑w/activity ○symptoms ↓w/activity

○getting worse ○getting better ○no change

Treatment received: ______________________

[LIST SELF-CARE ROUTINES]

How do you reduce stress? ______________________

____

Pain? ______________________

____

Current Medications: *(include pain relievers and herbal remedies)*

____

____

Have you ever received massage therapy before?

○yes ○no

Frequency: ______________________

What are your goals for receiving massage therapy?

____

____

____

[HEALTH HISTORY]

List and explain. Include dates and treatment received.

Surgeries: ______________________

____

____

Injuries: ______________________

____

____

Major Illnesses: ______________________

____

____

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*Visit us online at LissetteMassage.com to schedule an appointment.

CHECK ALL CURRENT AND PREVIOUS CONDITIONS. PLEASE EXPLAIN.

[GENERAL]

current	past	comments
○	○	Headaches: ______
○	○	Fatigue: ______
○	○	Fever: ______
○	○	Sinus: ______

[SKIN CONDITIONS]

current	past	comments
○	○	Rashes: ______
○	○	Athlete's Foot, Warts: ______
○	○	Other: ______

[MUSCLES AND JOINTS]

current	past	comments
○	○	Rheumatoid Arthritis: ______
○	○	Osteoarthritis: ______
○	○	Osteoporosis: ______
○	○	Scoliosis: ______
○	○	Spinal Problems: ______
○	○	Disk Problems: ______
○	○	Lupus: ______
○	○	Sprains, Strains: ______
○	○	Neck, Shoulder, Arm Pain: ______
○	○	Low Back, Hip, Leg Pain: ______
○	○	Other: ______

[NERVOUS SYSTEM]

current	past	comments
○	○	Head Injuries, Concussions: ______
○	○	Sciatica, Shooting Pain: ______
○	○	Depression: ______

[RESPIRATORY, CARDIOVASCULAR]

current	past	comments
○	○	Blood Clots: ______
○	○	Stroke: ______
○	○	Lymphadema: ______
○	○	High, Low Blood Pressure: ______
○	○	Heart Disease: ______
○	○	Irregular Heart Beat: ______
○	○	Poor Circulation: ______
○	○	Swollen Ankles: ______
○	○	Chest Pain, Shortness of Breath: ______
○	○	Asthma: ______

[ALLERGIES]

current	past	comments
○	○	Scents, Oils, Lotions: ______
○	○	Detergents: ______
○	○	Other: ______

CONTRACT FOR CARE

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self-care program we select. I promise to inform my practitioner any time feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

CONSENT FOR CARE

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

NAME: ______

SIGNATURE: ______

DATE: ______