

N.E. Medical Massage Therapy
New Patient Registration

Name: _____ Home Phone: (____) _____ Today's Date: __/__/__

Address: _____ Work Phone: (____) _____ Occupation: _____

City: _____ State: _____ Zip: _____ Email: _____

Date of Birth: ____/____/____ Gender: M ___ F ___

Are you presently treated by: MD? ___ Chiro? ___ PT? ___ Acup? ___ Other _____

Physician: _____ Location: _____ Phone #: (____) _____

HMO/Insurance Provider: _____ Member ID#: _____

Present Medications: _____

Recent Surgery or Injury: _____

In Case of Emergency: _____ Phone: (____) _____

Referred By: () Friend/Co-worker _____ () Dr./PT _____
() Newspaper _____ () Yellow Pages _____ () Other _____

Please check the appropriate box for any of the following that you have or have had previously.

GENERAL MEDICAL

- Food Allergies
- Skin Allergies
- Cancer
- Chronic Fatigue
- Headaches
- Depression / Anxiety
- Diabetes
- Asthma
- Difficulty Sleeping
- Nerve Pain
- Numbness

GASTRO-INTESTINAL

- Constipation
- Diarrhea
- Nausea
- Stomach Pain
- Ulcers

EYES / EARS / THROAT

- Cold (current)
- Deafness
- Enlarged Glands
- Hay Fever / Allergies

MUSCULOSKELETAL

- Arthritis
- Back Pain – Lower
- Back Pain – Middle
- Back Pain – Upper
- Bursitis
- Gout
- Joint Swelling
- Joint Replacement
- Pain between shoulders
- Multiple Sclerosis

RESPIRATORY

- Chest Pain
- Difficulty Breathing
- Chronic Cough
- Tuberculosis

SKIN

- Acne
- Bruise Easily
- Eczema / Psoriasis
- Open Wounds / Sores
- Rashes
- Skin Cancer
- Other _____

PAIN OR NUMBNESS IN:

- Arms Elbows
- Wrists Hands
- Neck Shoulders
- Hips Tailbone
- Legs Calves
- Knees Ankles
- Feet

CARDIAC / CIRCULATORY

- Aneurysm
- Hardening of the Arteries
- Heart Disease
- High Blood Pressure
- Poor Circulation
- Stroke
- Varicose Veins

WOMEN ONLY

- Are you pregnant? Y / N
- Gynecological Problems
- Menstrual Problems
- PMS

Comments / Additional Information:

OVER>>

Previous Massage Therapy? Y / N Date of last treatment? _____
What level of massage pressure do you prefer? () Light () Medium () Strong
Are you in pain now? Y__ N__ Describe: _____
Please mark any areas of pain: () Mild () Moderate () Severe

Comments:

LIFESTYLE:

Home Life: () Stressful much of the time () Stressful sometimes () Not stressful
Work Life: () Stressful much of the time () Stressful sometimes () Not stressful
Exercise: () Frequently () Regularly () Sometimes () Not usually
Eat Well: () Always () Mostly () Usually () Not usually
Sleep Well: () Always () Mostly () Usually () Not usually

Please take a moment to read the following information and sign where indicated:

I understand that the massage therapy I receive is for the purpose of stress reduction, relief from muscular tension or spasm, or for improving circulation. I further understand that a massage therapist is not qualified to diagnose illness, disease, or any other medical disorder and does not perform high velocity joint manipulations. I understand that massage therapy is contraindicated for some medical conditions and failure to disclose such conditions could result in injury or increase symptoms for which the therapist will not be held liable. I am responsible for consulting a qualified physician for any ailment that I may have. A referral from your primary care provider may be required prior to the massage service. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so.

CANCELLATIONS:

I have read the "Appointment Policies" of N.E. Medical Massage Therapy and agree to adhere to the terms as required.

I agree to pay for all services at the time they are rendered.

Patient Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to treatment of minor: By my signature below, I hereby authorize _____
To administer massage therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____