Advance Medical Massage

"Relaxation Speicalist"

Please fill out our *confidential* patient health record completely and accurately. *All* of the information is needed for billing and record keeping purposes. If you have any questions, please don't hesitate to ask.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being possible.

Personal Information

Name:

Address:

City: Zip:

Home PH: Cell PH:

Work PH:

Date of Birth: Gender: Male / Female

Marital Status: Single Married Divorced Separated Widowed

Number Children: Are you a Student? Y / N

Email Address:

Employment Status: Full Time Part Time Not Employed Self Employed Retired Military Duty Disabled

Employer:

Address:

Responsible Party or Person Responsible for Minor (Under the age of 18)

Name:

Date of Birth:

Relationship to Client:

Address:

Home PH: Cell PH:

Work PH:

Employment Status: Full Time Part Time Not Employed Self Employed Retired Military Duty Disabled

Employer:

Address:

Emergency Contact

Name: Relationship:

Home PH: Work PH: Address:

Cell PH:

Experience with Treatment

How did you hear about Advance Medical Massage?

Do you have family who are treated here?

Have you had a massage before? Y / N
Approximate date of last visit:

Have you had Hot Stone Therapy before? Y / N
Type of Treatment and results:

Medical Massage Therapy is a soft tissue therapy that utilizes massage, manual joint mobilization, hot/cold therapy, and therapeutic exercise procedures to reduce pain, spasm, and inflammation. By signing below, I hereby authorize any treatment and care given and will be financially responsible for services received. If missed appointment with no call $25.00 charge to account.

Signature: Date:

WHAT ARE YOU LOOKING FOR TODAY

What (specifically) would you like to receive from your appointment today?

Would you like me to focus on or target any specific areas today?

Would you like me to stay away from any specific areas?

HEALTH INFORMATION

Are you or have you ever had any of the following conditions (Please circle yes or no)

Smoker?	Yes or No	Pregnant?	Yes or No
High Blood Pressure?	Yes or No	Allergies?	Yes or No
Low Blood Pressure?	Yes or No	Seizures?	Yes or No
Epilepsy?	Yes or No	Varicose Veins?	Yes or No
Frequent Headaches?	Yes or No	Dementia?	Yes or No
Nausea?	Yes or No	Skin Conditions?	Yes or No
Contagious Disease?	Yes or No	Heart Conditions?	Yes or No
Diabetic?	Yes or No	Cancer?	Yes or No
Frequent Anxiety?	Yes or No	Surgeries?	Yes or No

Please explain any yes answers:

Are you currently suffering from pain related to traumatic experience (i.e.: car accident, sports injuries, surgeries) Y/ N
If yes, briefly explain (what and when):

Are you currently taking any medications or supplements (prescription and non-prescription) Y/N
If yes, list names and dosage of all medications:

I attest that the above information is true and accurate to the best of my knowledge.

Signature:_____ **Date:**_____ **Therapists Initials:**_____
If minor, signature of guardian required:_____ **Date:**_____

Disclaimer: By signing above, I agree that I understand that a massage therapist is not a doctor and cannot prescribe medication or diagnose medical conditions. The therapists does not discriminate on the basis of race, religion, age, gender and sexual preference.