HI-MED Therapeutic
Massage & Wellness Clinic

NEW PATIENT FORM

Patient Data **Date**_____

First Name _____ Middle Initial ____ Last Name _____

Address _____ City _____

State _____ Zip Code _____

Home Phone(_____)_____-_____ Work Phone(_____)_____-_____

Cell Phone (_____) _____-_____ Email _____

Date of Birth _____/_____/_____ Sex: Male Female

Marital Status: Single Married Other Employer: _____

Personal Health Insurance

No Fault Work Comp Other

Insurance Company:_____ Claim No._____

Adjuster Name:_____ Phone:_____

Emergency Contact_____

Contact Name _____ Relationship to Patient _____

Contact Home Phone (___) _____-_____ Cell Phone (____) ____-_____

Medical History/ Conditions/ Allergies_____

_____

_____

Are you pregnant? Yes No N/A

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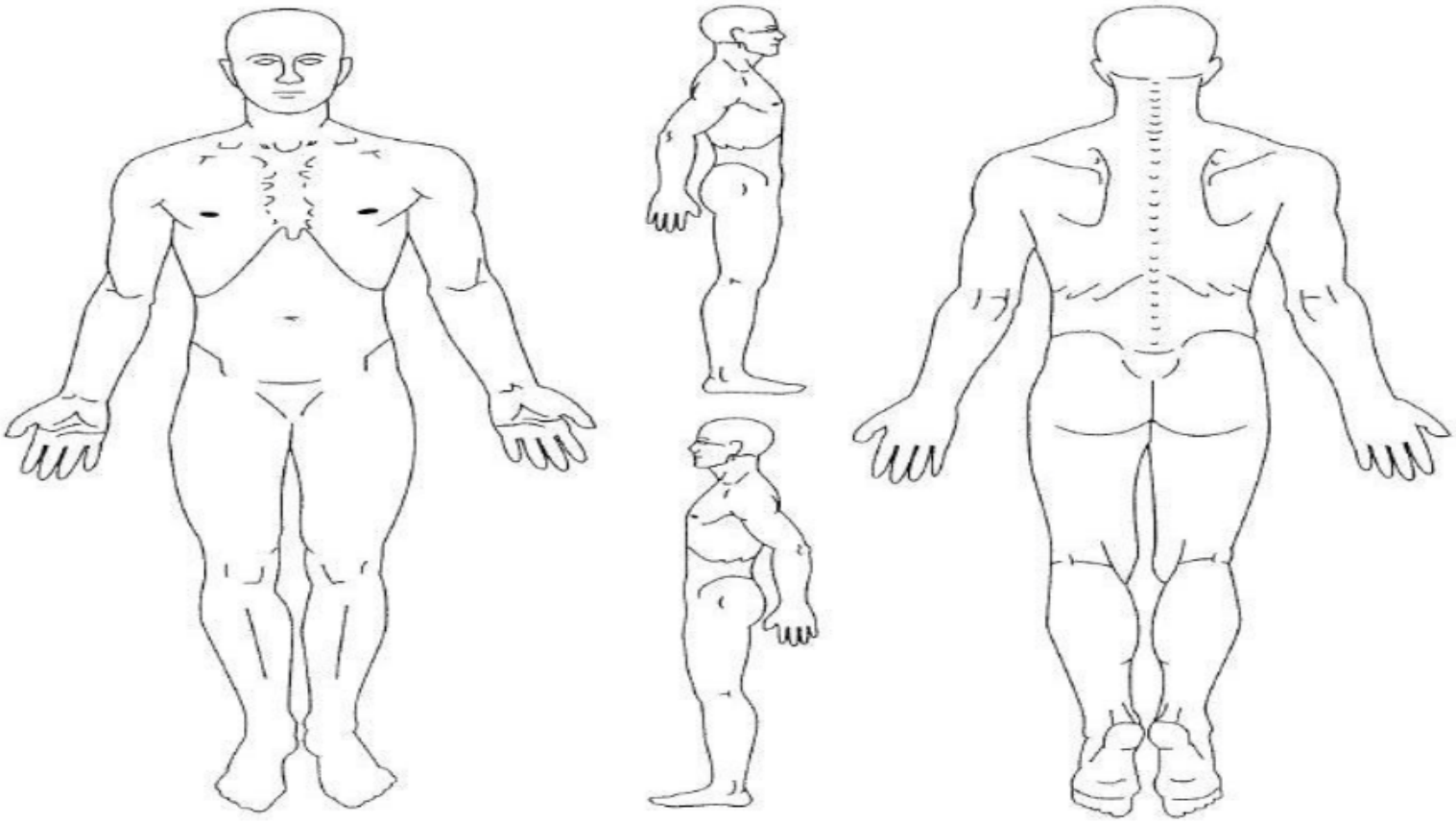
By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10 = the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms in order of severity, with worse symptom being #1:

_____

_____

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HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____

Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date_____