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 (____) ______

#20573 – © 2004 Medical Arts Press® 1-800-328-2179

6 MASSAGE 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. ______

______

7 HEALTH HISTORY

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

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

8 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.

______ Signature of Patient, Parent, Guardian or Personal Representative

______ Date

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

______ Relationship to Patient