

Healing Touch Clinical Massage Patient Health Record

Office use Only

Ther: _____

Date: _____

#: _____

Please fill out our *confidential* patient health record completely and accurately.

Clinical Massage Therapy is a soft tissue therapy that utilizes deep tissue massage, manual joint mobilization, hot/cold therapy, and therapeutic exercise procedures to reduce, pain, spasm, and inflammation.

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.

ABOUT THE PATIENT

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: (____) _____ Home : (____) _____

Email: _____

Birthdate: _____ Gender: M F

Marital Status Married Single Divorced
 Separated Widowed

Number of Children: _____ Are you a student? Y N

Employer: _____

Type of Work: _____

Work Phone: (____) _____

HOW DID YOU HEAR ABOUT THE OFFICE?

Drive By Google Facebook

Website Flyer Phone Book

Referral: _____

Other: _____

Do you have family or friends who are treated here?

Yes No

INSURANCE

Will you be using health insurance?

(This is not common.)

Yes No

If yes, we will need some additional information about the person who holds the insurance policy.

EXPERIENCE WITH TREATMENT

Have you had a massage before? Yes No

Approximate date of last visit: _____

Type of Treatment: Clinical Relaxation Other

What were your results? _____

IN AN EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Cell Phone: (____) _____

Other Phone: (____) _____

REASON FOR THIS VISIT

Tell us about your symptom(s): _____

Is the purpose of this visit related to: Job Sports Injury Auto Accident Home Injury
 Chronic Discomfort Fall Other, Please explain: _____

If job or auto related, have you made a report of your accident to your employer or insurance agent? Yes No

When did these symptoms begin? _____

Since they started, have the symptoms: Gotten worse Stayed the same Gotten Better Come & Go

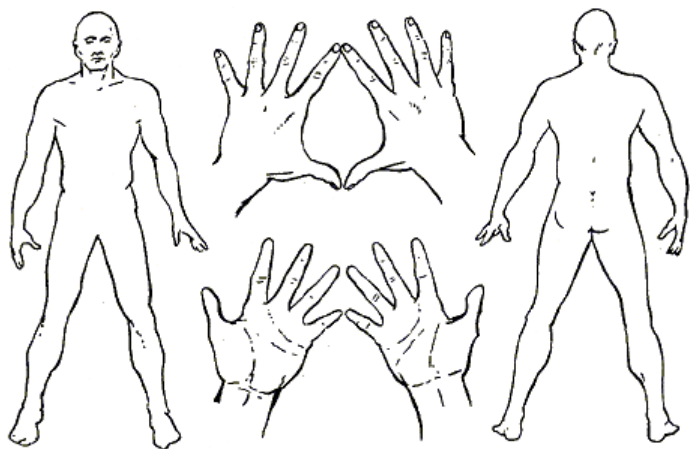
Do these symptoms interfere with: Work Sleep Daily Activities Other: _____

Have these symptoms occurred before? Yes No If yes, when: _____

Have you seen any other health care providers *for the same symptoms*? Yes No

If yes: Provider's Name(s): _____

Type of treatment and results: _____



Use the symbols below to show us where your symptoms are on the pictures to the left.

Sharp pain: / / / / / / / /
Dull/aching pain: ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
Stabbing pain: △ △ △ △ △ △
Weakness: # # # # # # # #
Numbness: + + + + + + + +
Burning: X X X X X X X X
Pins and needles: O O O O O O O O

MEDICATIONS PATIENT TAKES

- | | |
|-----------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Nerve Pills | <input type="checkbox"/> Muscle Relaxers |
| <input type="checkbox"/> Pain Killers (including Aspirin) | |
| <input type="checkbox"/> Blood Pressure Medicine | |
| <input type="checkbox"/> Anti-inflammatory Medicine | |
| <input type="checkbox"/> Stimulants | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

OTHER HEALTH CONCERNS

Do you have any other health conditions that may cause complications with your treatment? (i.e. bruise easily, etc.)

Please Explain: _____

Healing Touch Clinical Massage requires 24 hours notice of cancellation. Failure to cancel within the allotted time frame will result in a \$25 cancellation fee. If you do not contact us or do not show up this will result in 100% of the service fee being charged to you. Please keep in mind that no shows or last minute cancellations prevent other guests from receiving services during that appointment time. Thank you in advance for your cooperation.

By signing below, I understand this office has a zero balance policy and that all fees must be paid when services are rendered. I agree to and understand the cancellation & no show fees. I also understand that the massage therapists at Healing Touch Clinical Massage do not diagnose patients. I consent to receive treatment from the licensed therapists at Healing Touch Clinical Massage.

Print Name

Signature

Date