



Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Social Security #: _____ Age: _____ Birth date: ____/____/____

Sex: M / F Occupation: _____ Employer: _____ Wk. Ph: _____ Cell Ph: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Occupation: _____ Employer: _____

Person Responsible for this Account: _____ Health Plan: _____

Subscriber's Name: _____ ID#: _____ Group#: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP)? _____

WHO REFERRED YOU TO THIS CLINIC? _____

PLEASE DESCRIBE YOUR CURRENT PROBLEM. _____

HOW DID YOUR PROBLEM BEGIN? _____

DATE PROBLEM BEGAN: ____/____/____ IS THIS WORK RELATED AUTO RELATED N/A?

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION? (surgery, medications, therapy, chiropractic, etc.)

HAVE YOU HAD X-RAYS, MRI OR OTHER TESTS FOR THIS CONDITION? WHAT TESTS AND WHEN? _____

How bad is your pain? (Circle the number.)										
0	1	2	3	4	5	6	7	8	9	10
No pain										Unbearable Pain

How often are your symptoms present? Constantly Frequently Occasionally Intermittently

Have you had spinal x-rays, MRI, CT scan for your area(s) of complaint? Yes No

Dates(s) taken: _____ What areas were taken?: _____

Please check all of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Recent fever | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Stroke (date) _____ | <input type="checkbox"/> Currently pregnant, # weeks _____ |
| <input type="checkbox"/> Corticosteroid use (cortisone, prednisone, etc.) | <input type="checkbox"/> Abnormal weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Taking birth control pills | <input type="checkbox"/> Marked morning pain/stiffness |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain unrelieved by position or rest |
| <input type="checkbox"/> Numbness in groin/buttocks | <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> Cancer/Tumor (explain) _____ | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Surgeries: _____ |
| <input type="checkbox"/> Epilepsy/Seizures | _____ |
| <input type="checkbox"/> Other Health Problems (explain) _____ | <input type="checkbox"/> Medications: _____ |
| | _____ |

Family History: Cancer Diabetes High Blood Pressure
 Heart problems/Stroke Rheumatoid arthritis/Auto-immune disease _____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my massage therapy provider or clinical peer employed by my health plan may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my massage therapy provider and/or my health plan to contact my physician, if necessary.

Patient Signature: _____ Date: _____