Associates Therapeutic Massage
New Patient Information Form

For office use only
REVIEWED
P Card
REF'L

Name: _____ Birthday: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

Email: _____ Occupation: _____

Personal Physician: _____ **How did you hear about us?** _____

Medications: _____

PREVIOUS HISTORY (please include year and treatment received)

Surgeries: _____

Accidents: _____

HEALTH HISTORY

Musculo-Skeletal

__bone or joint disease _____
__tendonitis _____
__bursitis _____
__broken / fractured bones _____
__arthritis _____
__sprains / strains _____
__low back, hip, leg pain _____
__neck, shoulder, arm pain _____
__headaches / head injuries _____
__spasm / cramps _____
__jaw pain / TMJ _____
__lupus _____
__other _____

Circulatory

__heart condition _____
__varicose veins _____
__blood clots _____
__high blood pressure _____
__low blood pressure _____
__lymphedema _____
__breathing difficulty _____
__sinus problems _____
__asthma _____
__allergies _____
__other _____

Please See Other Side

SKIN

__allergies_____
__rashes_____
__athletes foot_____
__warts_____
__other_____

INFECTIOUS DISEASE

__disease name(s):_____
_____
_____

NERVOUS SYSTEM

__herpes/shingles_____
__numbness/tingling_____
__chronic pain_____
__fatigue_____
__sleep disorders_____
__other_____

DIGESTIVE

__constipation_____
__gas/bloating_____
__diverticulitis_____
__irritable bowel syndrome_____
__other_____

REPRODUCTIVE

__pregnant? Stage_____
__PMS_____
__other_____

OTHER

__bladder problems_____
__prostate problems_____
__cancer/tumors_____
__diabetes_____
__eating disorders_____
__depression_____
__drug/alcohol addiction_____
__nicotine/caffeine addiction_____

It is my choice to receive massage therapy or integrated manual therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well being is being compromised.

I understand that massage therapist or manual practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage therapy or manual therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage therapist or manual practitioner of any changes in my health status.

SIGNATURE:_____ DATE:_____