

Patient Name

Date

New WELLNESS MASSAGE Client Information & Medical History

TELL ME ABOUT YOUR PAIN

How to Rate Your Pain (1-10)

Circle the number that best represents the pain you are experiencing today

10	Your pain is intense, constant , greatly restricts activities , and it is impossible to go more than 5 minutes without being aware of the pain	5	Your pain is moderate , yet too frequent to ignore. Few activities are affected . Hours can go by without being aware of the pain
9	Your pain is intense, constant , greatly restricts activities , but you can forget about it for up to 15 minutes at a time	4	Your pain is more than a nuisance , and you go through your day frequently aware , but not affected by it.
8	Your pain is significant , moderately intense at times, but not constant . Activities are affected , and you are aware of it at least twice an hour	3	Your pain is little more than a nuisance , your awareness of the pain may be absent for a whole day at a time, and it does not affect your activities.
7	Your pain is significant at times, but not intense , and not constant . Most activities are affected , and you are aware of it one or twice an hour	2	At it's worst, your pain is best described as uncomfortable . Days can go by without being aware of it.
6	Your pain is moderate , yet too frequent to ignore. Some activities are affected . Hours can go by without being aware of the pain	1	At it's worst, your pain is best described as uncomfortable , and symptoms do not occur more frequently than once a week .

Are you suffering from any of the following?

- Stress** (how often? _____ frequency)
- Headaches** (how often? _____ frequency)
(how long do they last? _____ hours/all day? duration)
(how bad are they? _____ # intensity) **Face/Jaw** Pain
- Neck** pain [Upper Lower Left Right All of it]
- Face/Jaw** pain [Upper Lower Left Right All of it]
- Shoulder** pain [Left Right Both]
- Back** pain [Upper Mid Lower Left Right All of it]
- Hip/Buttock** pain [Left Right Both]
- Extremity** pain [Arm [L/R] Wrist [L/R] Hand [L/R]
Leg [L/R] Knee [L/R] Ankle [L/R] Foot [L/R]
- Sleep difficulty** [due to pain restless insomnia]

Please mark all the areas of discomfort on the figures to the right → and circle your symptoms below:

intense	significant	moderate	nuisance	uncomfortable
constant	comes & goes	spasms	aching	tingling
stabbing	Pins & needles	stiffness	numbness	weakness

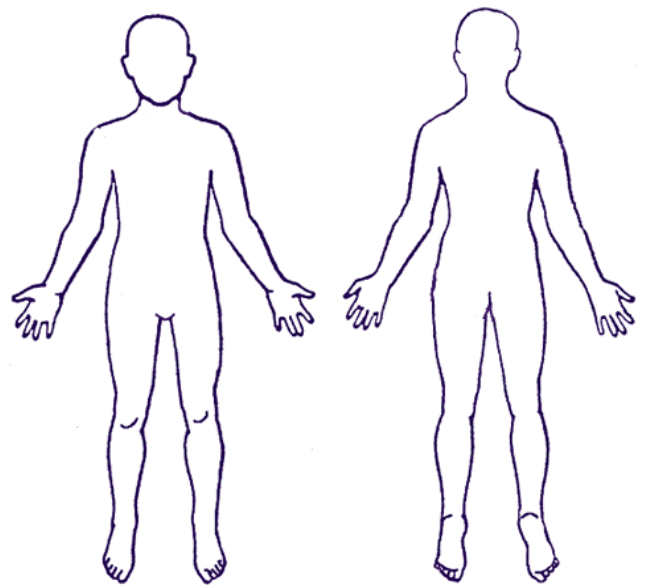
What makes it better? _____

What makes it worse? _____

How does your pain/symptoms affect your life and work?

(what are you not able to do that you could do before?) Use margin if necessary

WHERE IS YOUR PAIN?



Front

Back

Patient (or Guardian) Signature

Who can I Thank for Referring You? _____

Name _____ Email address _____

Mailing Address _____

City _____ State _____ Zip _____

Date of Birth _____ Male Female Married Single (not required)

Home Phone _____ Cell Phone _____

Do NOT contact me about future discounts and other offers

MEDICAL HISTORY

Please check Yes or No to the following questions, and explain in spaces provided

Yes No

Are you wearing any medical devices (Contacts, Dentures, Hearing Aid, Other _____)

Do you suffer from any of the following?
 Skin disorders (Rash, Yeast, Fungus, Psoriasis, Acne, Infection, _____)
 Food/Ingredient Allergies (Oils, Nuts, Herbs, Skin Care Ingredients, _____)

Are you under the care of a physician for any reason other than your accident? _____

Are you taking any medications? How long ago was your last dosage? _____

Any current/recent illnesses? Infectious, Viral, Bacterial, Diagnosis _____

Have you ever been diagnosed with any of the following conditions?
 Arthritis. Type and location(s) _____
 High Blood Pressure, Low Blood Pressure, Aneurism, Embolism, Other _____
 Heart Disease (diagnosis _____)
 Diabetes (Type I, Type II
 Cancer (type/location _____)
 Spinal condition Scoliosis, Osteoporosis, Other _____
 Other Medical Condition _____

Have you ever had surgery? What part of body? _____, Date _____

Do you have any needs that requie special asttention? What _____

Do you have any questions before we get started? _____

WOMEN ONLY

Menstrual Pain/Cramping, Irregularity. Date of last period _____

Are you now pregnant? What trimester _____. Any problems? _____

Cancellation Policy

Your scheduled appointments are reserved exclusively for you, and I take pride in my commitment to you in keeping all our appointments as scheduled. Your courtesies and cooperation in honoring the time you schedule with me is greatly appreciated so that I may provide the best possible care at the most affordable rates for all my clients, and support my family from the services I provide you. **Please PHONE AS SOON AS YOU KNOW YOU CANNOT MAKE AN APPOINTMENT** so that I can offer your scheduled time to another client. All cancellations made after 5 p.m. the weekday before will be billed to you for the time and services you reserved.

I understand that Massage Therapy is in no way to be used instead of or in place of consulting with a Physician for diagnosis and treatment of any physical symptom(s), but to be used as a complimentary therapy in conjunction with, or on the advice of, referral or prescription from my Physician(s). By my signature, I verify that all information provided above is true and correct. I have read, undersand and agree to the Cancellation Policy, and I promise to keep my health care providers, including my Massage Therapist, updated on any changes in my health and residence.

Patient (or Guardian) Signature

Date _____