

# 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 (\_\_\_\_\_) \_\_\_\_\_

## 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:

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