MASSAGE THERAPY REGISTRATION AND HISTORY

1 CLIENT INFORMATION

Date_____

Client_____

Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

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, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to _____ 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 hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Ext____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____ Work Phone_____

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_____

– TO REVERSE SIDE –

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:

- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Breathing Difficulty
- ☐ Bursitis
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaw Pain/TMJ
- ☐ Lymphedema
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tendonitis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Whiplash
- ☐ 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 or muscle diseases or injuries not specified above.

_____ _____ _____ _____

Date Date

8 AUTHORIZATION

I certify that the above information is correct to the best of my knowledge. I will not hold my massage therapist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

I have disclosed all medical conditions that I am aware of and will inform my massage therapist of any changes in my health status.

I hereby request the aforementioned health care providers release to you a report of my diagnosis, treatment, prognosis and recommendations, and other information pertinent to your treatment of me.

I understand that massage therapy services are designed to be a health aid and are in no way a substitute for a doctor's care. Information exchanged during massage sessions is educational in nature and is to be used at my own discretion.

Date_____ Signature_____