

Patient Information

Name: _____ Today's Date _____
Last First M.I.

Address: _____
Number Street City State Zip

Phone: (____) _____ (____) _____ Email: _____
Home Alternate

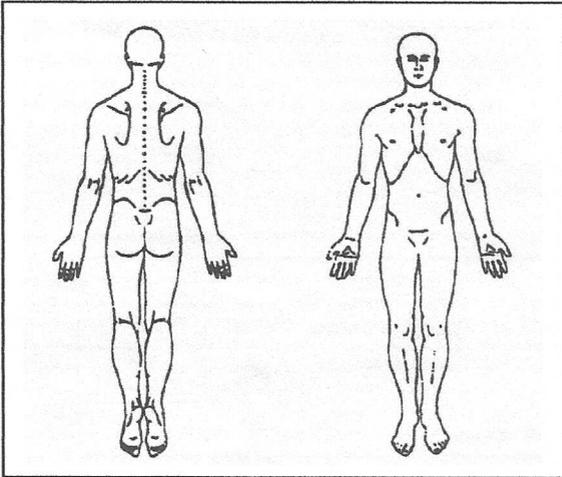
Date of Birth: _____ Employer: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone: (____) _____

Referred by: Person _____ Drivers license number and issue state _____

Symptoms

Please mark an "X" at any area of discomfort on the diagram.



Please circle which, if any, of the below activities are painful.

Sitting	Walking
Bending	Twisting
Standing	Running
Lying Down	Lifting

Please circle the type of discomfort you experience.

Shooting	Tingling
Dull	Sharp
Stiff	Achy
Numb	Throbbing
Weak	Tenderness
Burning	Pain
Spasms	Tightness
Fatigue	Itching
Radiating	Difficulty Sleeping

Please circle your level of discomfort.

1 2 3 4 5 6 7 8 9 10
 Low Severe

Please describe your chief health concern(s): _____

How long have you had these symptoms? _____

What aggravates your discomfort? _____

What relieves your discomfort? _____

Health History

Have you had any recent illnesses, accidents or surgeries? ()Y ()N If yes, please explain _____

Have you ever received a professional massage? ()Y ()N If yes, frequency & type: _____

List All Current Medications, Vitamins, and Supplements -- Include Prescription, Over the Counter & Herbal _____

List stress reduction & exercise activities: _____

Do you have problems with any of the following? Please mark "C" for current conditions, and "P" for Past:

- | | |
|--------------------------------|-------------------------|
| () Diabetes _____ | () Headaches _____ |
| () Skin Problems/Rashes _____ | () Allergies _____ |
| () Circulation Problems _____ | () Pregnancy _____ |
| () Cancer _____ | () Heart Disease _____ |
| () Chronic Illness _____ | () Arthritis _____ |
| () High Blood Pressure _____ | () Seizures _____ |
| () Infection _____ | () Other _____ |

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the **Notice of Privacy Practices** and I have been provided an opportunity to review it this _____ day of _____, _____ Year. *Please Initial* _____

I authorize Restorative Touch to consult other healthcare practitioners in regards to my therapy when necessary to provide the highest level of care. *Please check* _____ Yes _____ No

I understand that massage practitioners do not diagnose illness, disease, or other physical or mental disorders. Massage therapists do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

It is my choice to receive manual therapy. I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Client Signature

Date

Insurance Information (If applicable)

It will be the client's responsibility to pay any outstanding balance in full that is not covered by insurance with in 30 days of notification. *Initial here* (_____)

Name of Insurance Company: _____

Address: _____

Phone Number: (____) _____

Claim/Policy No. _____

Fax Number: _____

Contact Person: _____

Name of Insured: _____

Date of Birth: _____

Relation to Patient: _____

Phone Number: (____) _____

Address: _____

Referring Physician/Medical Professional: _____

Phone Number: (____) _____

Date of Injury: _____