Manual Therapist **Miller Medical Massage**

HEALTH INFORMATION

Patient Name _____ Date _____

Date of Injury _____ ID#/DOB _____

A. Patient Information

Email address: _____

Address _____

City _____ State ____ Zip _____

Phone: Home _____

Work _____ Cell _____

Employer _____

Work Address _____

Occupation _____

Emergency Contact _____

Phone: Home _____

Work _____ Cell _____

Primary Health Care Provider

Name _____

Address _____

City/State/Zip _____

Phone: _____ Fax _____

I give my massage therapist permission to consult with my health care providers regarding my health and treatment.

Comments _____

Initials _____ Date _____

B. Current Health Information

List Health Concerns Check all that apply

Primary _____

☐ mild ☐ moderate ☐ disabling
☐ constant ☐ intermittant
☐ symptoms ↑ w/activity ☐ ↓ w/activity
☐ getting worse ☐ getting better ☐ no change
treatment received _____

Secondary _____

☐ mild ☐ moderate ☐ disabling
☐ constant ☐ intermittant
☐ symptoms ↑ w/activity ☐ ↓ w/activity
☐ getting worse ☐ getting better ☐ no change
treatment received _____

Additional _____

☐ mild ☐ moderate ☐ disabling
☐ constant ☐ intermittant
☐ symptoms ↑ w/activity ☐ ↓ w/activity
☐ getting worse ☐ getting better ☐ no change
treatment received _____

List Daily Activities Limited by Condition

Work _____

Home/Family _____

Sleep/Self-care _____

Social/Recreational _____

List Self-Care Routines

How do you reduce stress? _____

Pain? _____

List current medications (include pain relievers and herbal remedies) _____

Have you ever received massage therapy before? _____ Frequency? _____

What are your goals for receiving massage therapy? _____

C. Health History

List and Explain. Include dates and treatment received.

Surgeries _____

Injuries _____

Major Illnesses _____

Check All Current and Previous Conditions Please Explain

General

current past comments

- ☐ ☐ headaches _____
- ☐ ☐ pain _____
- ☐ ☐ sleep disturbances _____
- ☐ ☐ fatigue _____
- ☐ ☐ infections _____
- ☐ ☐ fever _____
- ☐ ☐ sinus _____
- ☐ ☐ other _____

Skin Conditions

current past comments

- ☐ ☐ rashes _____
- ☐ ☐ athlete's foot, warts _____
- ☐ ☐ other _____

Muscles and Joints

current past comments

- ☐ ☐ rheumatoid arthritis _____
- ☐ ☐ osteoarthritis _____
- ☐ ☐ osteoporosis _____
- ☐ ☐ scoliosis _____
- ☐ ☐ broken bones _____
- ☐ ☐ spinal problems _____
- ☐ ☐ disk problems _____
- ☐ ☐ lupus _____
- ☐ ☐ TMJ, jaw pain _____
- ☐ ☐ spasms, cramps _____
- ☐ ☐ sprains, strains _____
- ☐ ☐ tendonitis, bursitis _____
- ☐ ☐ stiff or painful joints _____
- ☐ ☐ weak or sore muscles _____
- ☐ ☐ neck, shoulder, arm pain _____
- ☐ ☐ low back, hip, leg pain _____
- ☐ ☐ other _____

Nervous System

current past comments

- ☐ ☐ head injuries, concussions _____
- ☐ ☐ dizziness, ringing in ears _____
- ☐ ☐ loss of memory, confusion _____
- ☐ ☐ numbness, tingling _____
- ☐ ☐ sciatica, shooting pain _____
- ☐ ☐ chronic pain _____
- ☐ ☐ depression _____
- ☐ ☐ other _____

Respiratory, Cardiovascular

current past comments

- ☐ ☐ heart disease _____
- ☐ ☐ blood clots _____
- ☐ ☐ stroke _____
- ☐ ☐ lymphadema _____
- ☐ ☐ high, low blood pressure _____
- ☐ ☐ irregular heart beat _____
- ☐ ☐ poor circulation _____
- ☐ ☐ swollen ankles _____
- ☐ ☐ varicose veins _____
- ☐ ☐ chest pain, shortness of breath _____
- ☐ ☐ asthma _____

Allergies

current past comments

- ☐ ☐ scents, oils, lotions _____
- ☐ ☐ detergents _____
- ☐ ☐ other _____

Digestive/Elimination System

current past comments

- ☐ ☐ bowel problems _____
- ☐ ☐ gas, bloating _____
- ☐ ☐ bladder/kidney/prostrate _____
- ☐ ☐ abdominal pain _____
- ☐ ☐ other _____

Endocrine System

current past comments

- ☐ ☐ thyroid _____
- ☐ ☐ diabetes _____

Reproductive System

current past comments

- ☐ ☐ pregnancy _____
- ☐ ☐ painful, emotional menses _____
- ☐ ☐ fibrotic cysts _____

Cancer/Tumors

current past comments

- ☐ ☐ benign _____
- ☐ ☐ malignant _____

Habits

current past comments

- ☐ ☐ tobacco _____
- ☐ ☐ alcohol _____
- ☐ ☐ drugs _____
- ☐ ☐ coffee, soda _____

Contract for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

Consent for Care

It is my choice to receive manual therapy, and 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.

Signature _____ Date _____

Manual Therapist **Miller Medical Massage**

HEALTH REPORT

Patient Name _____ Date _____

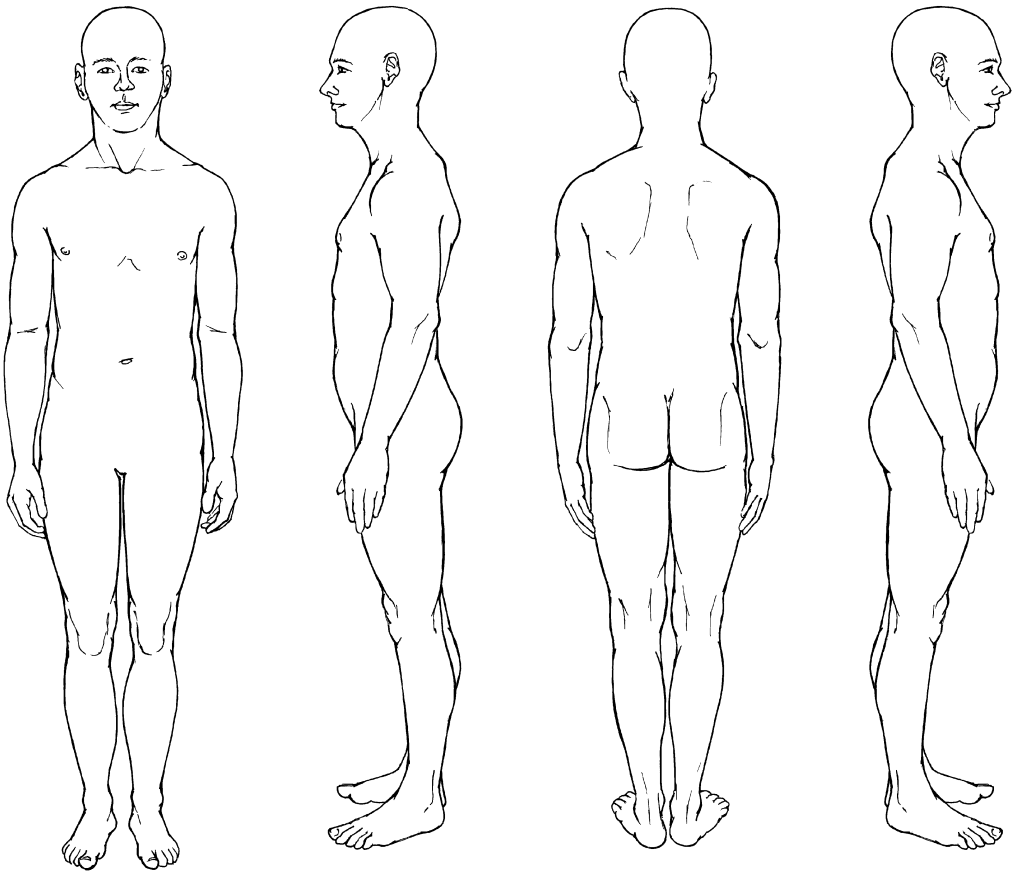
Date of Injury _____ ID#/DOB _____

A. Draw today's symptoms on the figures.

1. Identify CURRENT symptomatic areas in your body by marking letters on the figures below. Use the letters provided in the key to identify the symptoms you are feeling today.
2. Circle the area around each letter, representing the size and shape of each symptom location.

Key

P = pain or tenderness
S = joint or muscle stiffness
N = numbness or tingling



B. Identify the intensity of your symptoms.

1. Pain Scale: Mark a line on the scale to show the amount of pain you are experiencing today.

No Pain ——————————————— Unbearable Pain

2. Activities Scale: Mark a line on the scale to show the limitations you are experiencing today in your daily activities.

Can Do Anything I Want ——————————————— Cannot Do Anything

C. Comments

_____

_____

_____

_____

Signature _____ Date _____

CANCELLATION POLICY

Miller Medical Massage requires **48 hours** notice when canceling your appointment. This allows the front desk ample time to fill the appointment.

If you give our office less than **48 hours** notice or you do not show up then you will be charged **the entire dollar amount of the scheduled visit**. This must be paid immediately and before your next visit. If you have a card on file, we will charge this card unless you give us another form of payment at the time of cancellation. However, if you have a prepaid package, we will deduct one visit from your package instead of charging the card on file.

*Please note that this fee cannot be billed to insurance.

Please sign below indicating that you have read and are aware of our cancellation policy and agree to pay the **entire dollar amount** of the scheduled visit should you no-show or late cancel.

Name (please print):_____

Signature:_____

Date:_____

Thank you!