Patient Information

First Name: _____ MI: _____

Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced
□ Widowed □ Other _____

Date of Birth: _____

Whom may we thank for referring you here:
_____

Contact Information

Home Telephone No: ( ) _____

Work Telephone No: ( ) _____

Cell No: ( ) _____

E-Mail: _____

Emergency Contact Person and phone #:

_____

Current Symptoms

Have you ever received a massage before? _____

When? _____

What is your reason for getting a massage today?

□ Relaxation □ Pain □ Injury (Please include injury update)

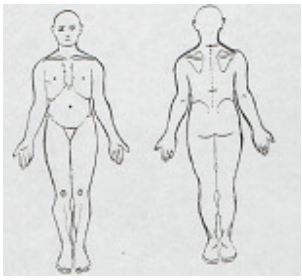
Are you currently under a physicians or other health professional's care?
_____

For what conditions?
_____

Current medications:
_____

Do you have any specific areas you would like me to focus on during this massage? _____

Are there any areas that you would like me to avoid?
_____



Please indicate symptoms with an X

Current/Recent Health History

(Please check all that apply)

□ Asthma	□ Arthritis	□ Back pain	□ Muscle function	□ Bruise easily	□ Other conditions
□ Cancer	□ Chronic Pain	□ Constipation	□ Scoliosis	□ Dislocation	□ (Please list)
□ Diabetes	□ Epilepsy	□ Fatigue	□ Rheum. Arthritis	□ Heart condition	□
□ Numbness	□ High Blood Press	□ Inflammation	□ Recent surgery	□ Skin condition	□
□ Spinal fusion	□ Phlebitis	□ Pregnancy	□ Broken bones	□ Sleep problems	□
□ Whiplash	□ Paralysis	□ Spasticity	□ Depression	□ Varicose veins	□
□ Blood clots	□ Sprain	□ Stroke	□ Heal slowly	□ Contact lenses	□
□ Cuts/Wounds	□ Sciatica	□ Headaches	□ Muscle strain/tear	□ Hearing aid	□

I understand that the services provided are not a replacement for medical, chiropractic or psychological care. Any information provided is solely for educational purposes only.

_____ _____ _____
Date Patient signature Print Name

I, _____ acknowledge that I have read, reviewed, understand and agree to the notice of privacy practices of Teri Harvey, NYS LMT, which describes her policies and procedures regarding the use or disclosure of my protected health information created, received or maintained by the practice.

_____ _____ _____
Date Patient signature Print Name