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:

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

_____ _____

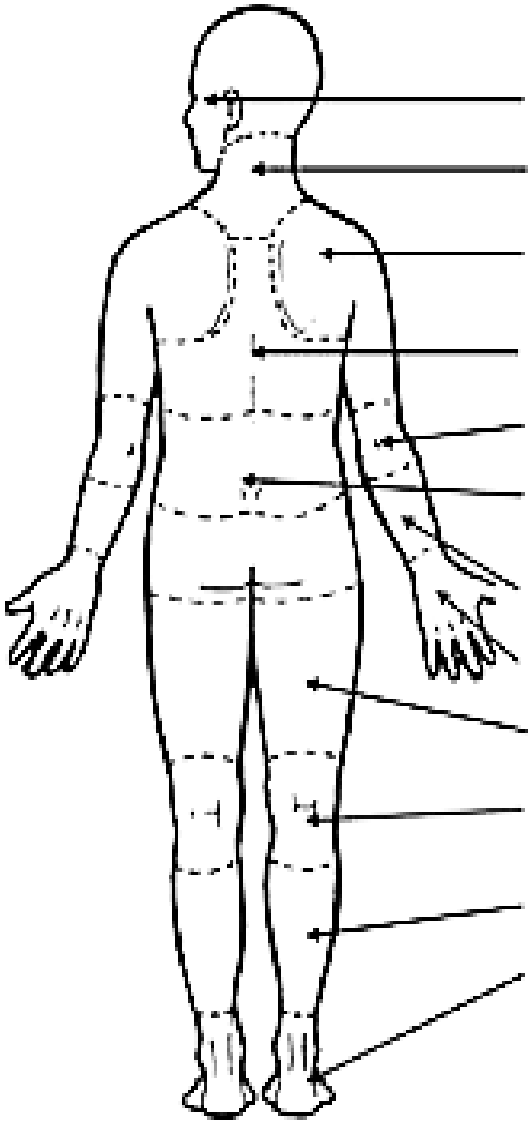
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Atlas Chiropractic
Health Center

Functional Pain Index

Please check the appropriate box to let us know how you feel *TODAY*.

Patient Name: _____Date: _____



Body Part	Right/Left	0	1	2	3	4	5	6	7	8	9	10
BODY-OVERALL												
Head												
Neck	Right/Left											
Shoulders/Chest	Right/Left											
Upper Back	Right/Left											
Elbow	Right/Left											
Lower Back	Right/Left											
Arm	Right/Left											
Wrist/Hand	Right/Left											
Pelvis/Hips	Right/Left											
Thigh	Right/Left											
Knee	Right/Left											
Lower Leg	Right/Left											
Feet/Ankle	Right/Left											

0-10 NUMERIC PAIN RATING SCALE