Bath City Chiropractic Clinic

Registration and History Form

PATIENT INFORMATION

Date: _____/_____/_____

Patient _____

Address _____

_____
City State Zip

Sex □ M □ F Age _____ Birthdate _____

Occupation _____

Employer _____

Spouse's Name _____

Sex □ M □ F Age _____ Birthdate _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

PHONE NUMBERS/ EMAIL

Cell _____ Provider_____

Home _____ Work _____

Email _____

Best time / place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Phone Number _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ڤ Yes ڤ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

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

Responsible Party Signature

Relationship Date

ACCIDENT INFORMATION

Is this 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?

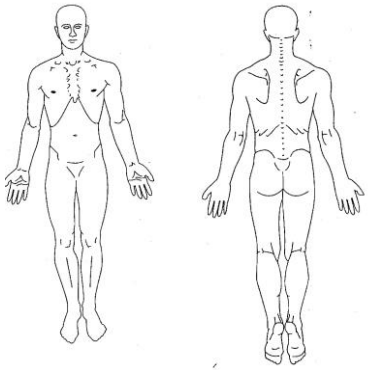
□ Auto Insurance □ Employer □ Worker Comp. □ Other

Attorney Name (if applicable) _____

Bath City
Chiropractic Clinic

PATIENT CONDITION

Reason for visit



_____

When did this symptom appear? _____

Is this condition getting progressively worse? □ Yes □ No □ Unknown

Mark an x on the picture where you continue to have pain, numbness or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other

How often do you have this pain?_____

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform □ Sitting □ Standing □ Walking □ Bending □ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? □Medications □Surgery □Physical Therapy □Chiropractic Service □None □Other _____ Name and address of other doctor(s) who have treated you for your condition _____

_____

Date of last exam: Physical Exam _____ Spinal X-ray_____ Blood Test_____
Spinal Exam_____ Chest X-ray_____ Urine Test_____
Dental X-ray_____ MRI, CT-Scan, Bone Scan _____

Check only those conditions that are applicable:

□ AIDS / HIV	□ Diabetes	□ Measles	□ Rheumatic Fever
□ Alcoholism	□ Emphysema	□ Migraine Headache	□ Scarlet Fever
□ Allergy Shot	□ Epilepsy	□ Miscarriage	□ Stroke
□ Anemia	□ Fractures	□ Mononucleosis	□ Suicide Attempt
□ Anorexia	□ Glaucoma	□ Multiple Sclerosis	□ Thyroid Problems
□ Appendicitis	□ Goiter	□ Mumps	□ Tonsillitis
□ Arthritis	□ Gonorrhea	□ Osteoporosis	□ Tuberculosis
□ Asthma	□ Gout	□ Pacemaker	□ Tumors, Growths
□ Bleeding Disorders	□ Heart Disease	□ Parkinson's Disease	□ Thyroid Fever
□ Breast Lump	□ Hepatitis	□ Pinched Nerve	□ Ulcers
□ Bronchitis	□ Hernia	□ Pneumonia	□ Vaginal Infections
□ Bulimia	□ Herniated Disk	□ Polio	□ Venereal Disease
□ Cancer	□ Herpes	□ Prostate Problem	□ Whooping Cough
□ Cataracts	□ High Cholesterol	□ Prosthesis	□ Other _____

□ Chemical Dependency □ Kidney Disease □ Psychiatric Care □ _____ □ Chicken Pox □ Liver Disease □ Rheumatoid Arthritis □ _____

EXERCISE	WORK ACTIVITY	HABITS	
□ None	□ Sitting	□ Smoking	Packs/Day _____
□ Moderate	□ Standing	□ Alcohol	Drinks/Week _____
□ Daily	□ Light Labor	□ Coffee/Caffeine Drinks	Cups/Day _____
□ Heavy	□ Heavy Labor	□ High Stress Level	Reason _____

Are you pregnant? □Yes □No Due Date _____

Injuries/Surgeries you have had

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS
_____ _____ _____ Pharmacy_____ Name _____ Pharmacy Phone _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Bath City Chiropractic Clinic

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alterations of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of non-chiropractic findings, we will recommend that you seek the services of a health care provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I understand that chiropractic treatments have minimal inherent risk associated with the nature of the therapy. Including but are not limited to: sprains, strains, dislocations, fractures and strokes. I am fully aware of the risk. I consent to the treatments and all risk associated with the treatments.

I, _____ being the parent or legal guardian of _____, hereby grant permission to Dr. McFadden, Bath City Chiropractic Clinic to evaluate and treat _____.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

I, _____ have read and fully understand the above statements.
(please print your name)

_____ _____
(signature) (date)

Bath City Chiropractic Clinic

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that **Bath City Chiropractic Clinic PLLC** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review **Bath City Chiropractic Clinic PLLC** Notice of Privacy Practices prior to signing this document. **Bath City Chiropractic Clinic PLLC** Notice of Privacy Practices can been provided to me, upon my request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Bath City Chiropractic Clinic PLLC**. A copy of the Notice of Privacy Practices for **Bath City Chiropractic Clinic PLLC** is on display in the common waiting area of this practice. This Notice of Privacy Practices also describes my rights and **Bath City Chiropractic Clinic PLLC** duties with respect to my protected health information.

Bath City Chiropractic Clinic PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative _____ Date _____

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Bath City Chiropractic Clinic PLLC

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

Please Print
Clearly

1. Name (Last, First) _____
2. Email address: _____@_____
3. Preferred method for patient reminders **(Circle one): Email / Phone / Mail**
4. DOB: __/__/____
5. Gender **(Circle one): Male / Female**
6. Preferred Language: _____
7. Smoking Status (**Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked**
8. Family Medical History - Record ONE DIAGNOSIS in your Family History

   Who & DX (Ex. – Mom – Stroke) _____
9. Race **(Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer**
10. Ethnicity **(Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer**
11. Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

12. Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

1. I choose to **(circle one) decline/accept** receipt of my clinical summary after every visit.
   (These summaries are often blank because of the nature and frequency of chiropractic care.)
2. Patient Signature: _____ Date: _____

For office use only Height: _____ Weight:_____ Blood Pressure:_____ /_____

Massage Therapist

HEALTH REPORT-M

Client Name _____ Date _____

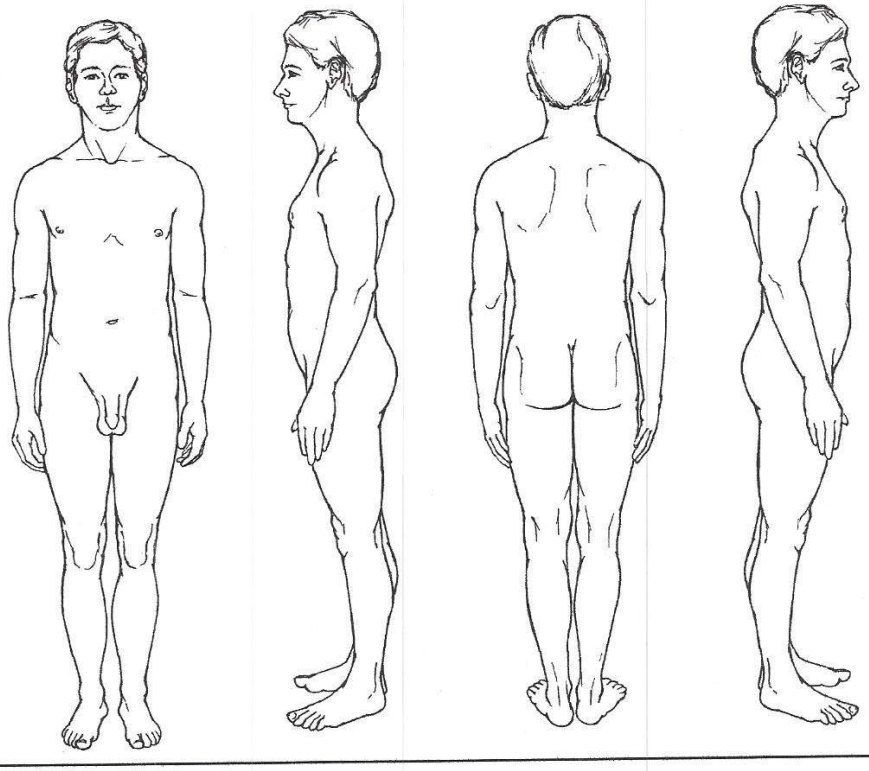
Date of Injury _____ ID#/DOB

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 _____

Massage Therapist

WELLNESS CHART-M

Name _____ ID#/DOB _____ Date _____

Phone _____ Address _____

1. What are your goals for health, and how may I assist you in achieving your goals? _____

2. List typical daily activities—work, exercise, home. _____

3. Are you currently experiencing any of the following? If yes, please explain.

pain, tenderness	☐ No ☐ Yes: _____		stiffness	☐ No ☐ Yes: _____	
numbness or tingling	☐ No ☐ Yes: _____		swelling	☐ No ☐ Yes: _____	
allergies	☐ No ☐ Yes: _____				

4. List all illnesses, injuries, and health concerns you have now or have had in the past 3 years. (Examples: arthritis, diabetes, car crash, pregnancy) _____

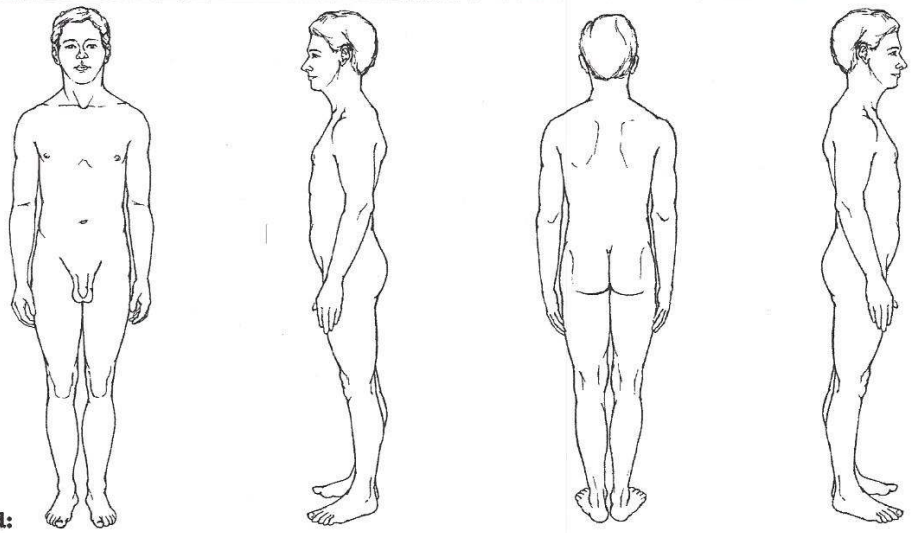
5. List medications and pain relievers taken this week. _____

6. I have provided all my known medical information. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

Signature _____ Date _____

Tx: _____

C: _____



Legend:

⊜ TP	• TeP	○ Ⓟ	✳ Infl	≡ HT	≈ SP	initials _____
⨯ Adh	≪ Numb	⟲ rot	⁄ elev	⟝ Short	⟷ Long	

Massage Therapist

HEALTH INFORMATION

Client Name _____ Date _____

Date of Injury _____ ID#/DOB _____

A. Client Information

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 massage 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 massage therapist to provide safe and effective treatment.

Consent for Care

It is my choice to receive massage 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 _____

Bath City Chiropractic Clinic

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident_____ Time of accident _____ AM / PM

Please Describe the accident in your own words _____

_____

_____

_____

Were you the: ف Driver ف Front Passenger
ف Rear Passenger ف Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City / State _____

Nearest Intersection _____

Diving Condition: فDry فWet فIcy ف _____

Which Direction were you heading? _____

Speed you were traveling? _____

Bath City Chiropractic Clinic

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐Yes ☐No

If yes, which type? ☐Lap ☐Shoulder

Was vehicle equipped with airbags? ☐Yes ☐No

If yes, did it/they inflate properly? ☐Yes ☐No

Did your seat have a headrest? ☐Yes ☐No

If yes, what was the position of the headrest?

☐Low ☐Midposition ☐High

OTHER VEHICLES
(if applicable)

Make and model of other vehicle _____

Direction other vehicle was heading _____

Speed of the other vehicle _____

IMPACT

Did your car impact another vehicle? ☐Yes ☐No

Did your car impact a structure? ☐Yes ☐No

If yes, explain _____

_____

Did any part of your body strike anything in the vehicle?

☐Yes ☐No If yes, explain _____

Was impact from: ☐Front ☐Rear ☐Left ☐Right ☐ _____

At time of impact were you:

☐Looking straight ahead ☐Looking to the right

☐Looking to the left ☐Looking down

☐Looking up

Were both hands on the steering wheel? ☐Yes ☐No

If no, which hand was on the wheel? ☐Left ☐Right

Was your foot on the brake? ☐Yes ☐No

If yes, which foot was on the brake? ☐Left ☐Right

Were you: ☐Surprised by impact ☐Braced for impact

POLICE

Did the police come to the accident site? ☐Yes ☐No

Were there any witnesses? ☐Yes ☐No

Was a police report filed? ☐Yes ☐No

Was a traffic violation issued? ☐Yes ☐No

If yes, to whom? _____

Bath City
Chiropractic Clinic

PATIENT CONDITION

Were you unconscious immediately after the accident? ف Yes ف No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

_____

_____

TREATMENT

Did you go to the hospital? ف Yes ف No

When did you go? ف Immediately after accident ف Next day ف 2 or more days after accident

How did you get to the hospital? ف Ambulance ف Private transportation

Name of Hospital _____ Name of Doctor _____

Diagnosis _____

Treatment received _____

X-rays taken _____

Bath City
Chiropractic Clinic

SYMPTOMS / INJURIES

Have you been able to work since this injury? ☐Yes ☐No How many days have you missed? _____

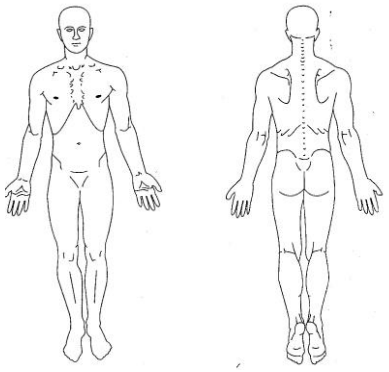
Prior to the injury were you able to work on an equal basis with others your age? ☐Yes ☐No

If you have had any of the following symptoms since your injury, please check the box.

☐ Arm / Shoulder pain ☐ Feet / Toe numbness ☐ Neck pain
☐ Back pain ☐ Hand / finger pain ☐ Neck stiff ☐ Back stiffness ☐ Headaches ☐ Shortness of breath ☐ Chest pain
☐ Irritability ☐ Sleep difficulty ☐ Dizziness
☐ Jaw problems ☐ Stomach upset ☐ Ear buzzing
☐ Leg pain ☐ Tension ☐ Ear ringing
☐ Memory loss ☐ Vision blurred ☐ Fatigue ☐ Nausea

Is this condition progressively getting worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling
☐ Cramps ☐ Stiffness ☐ Swelling ☐ _____

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 ☐ _____

I certify that the above information is correct to the best of my knowledge.

Patient Signature _____ Date _____

Massage Therapist

HEALTH REPORT-F

Client Name _____ Date _____

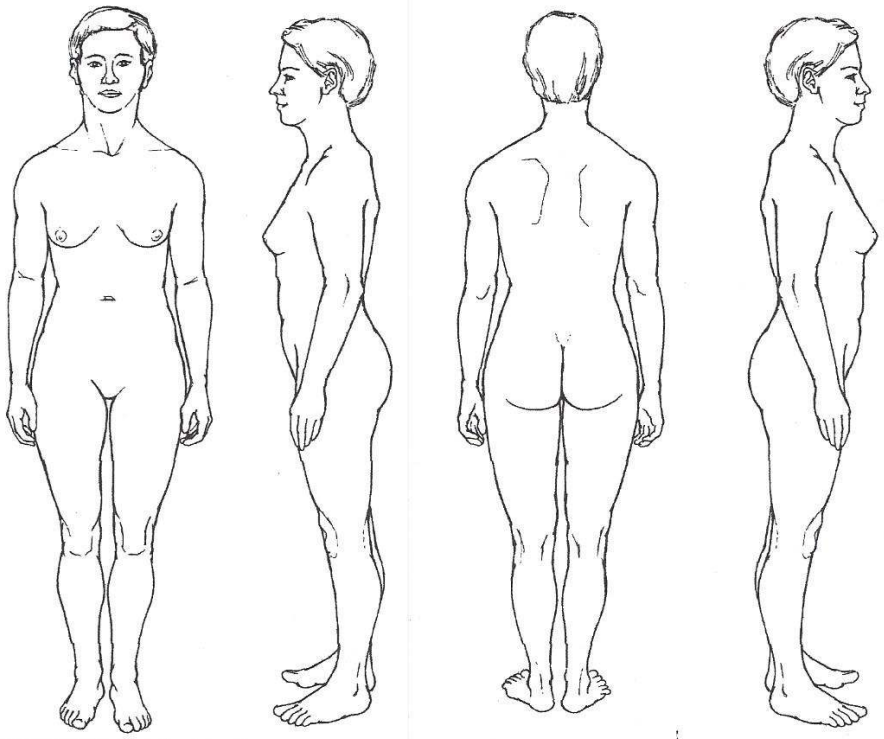
Date of Injury _____ ID#/DOB _____

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 _____

Massage Therapist

WELLNESS CHART-F

Name _____ ID#/DOB _____ Date _____

Phone _____ Address _____

1. What are your goals for health, and how may I assist you in achieving your goals? _____

2. List typical daily activities—work, exercise, home. _____

3. Are you currently experiencing any of the following? If yes, please explain.

pain, tenderness	☐ No ☐ Yes: _____		stiffness	☐ No ☐ Yes: _____	
numbness or tingling	☐ No ☐ Yes: _____		swelling	☐ No ☐ Yes: _____	
allergies	☐ No ☐ Yes: _____				

4. List all illnesses, injuries, and health concerns you have now or have had in the past 3 years. (Examples: arthritis, diabetes, car crash, pregnancy) _____

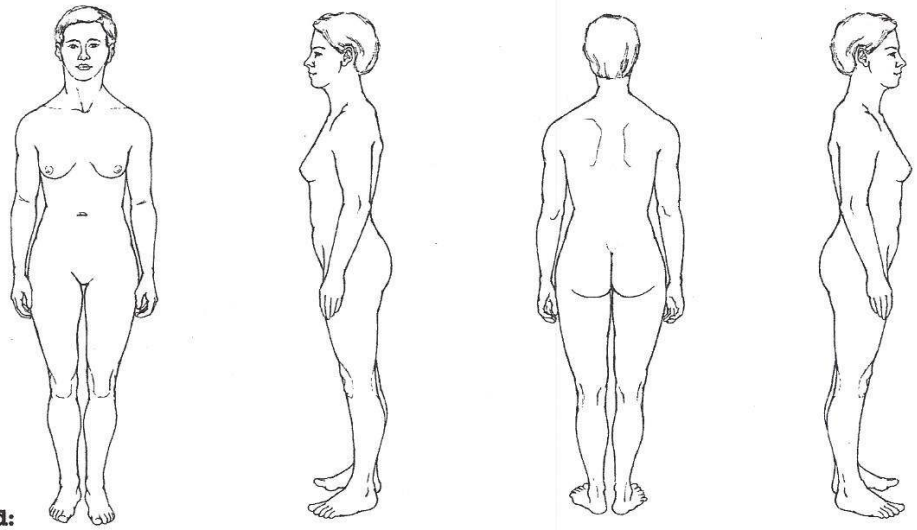
5. List medications and pain relievers taken this week. _____

6. I have provided all my known medical information. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

Signature _____ Date _____

Tx: _____

C: _____



Legend:

⊜ TP	• TeP	○ Ⓟ	✳ Infl	≡ HT	≈ SP	initials _____
× Adh	≪ Numb	⟲ rot	⁄ elev	⟝ Short	⟷ Long	

Massage Therapist

HEALTH INFORMATION

Client Name _____ Date _____

Date of Injury _____ ID#/DOB _____

A. Client Information

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 massage 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 massage therapist to provide safe and effective treatment.

Consent for Care

It is my choice to receive massage 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 _____

WORKERS' COMPENSATION HISTORY

Name_____ Age_____ Date of Birth_____/_____/_____ ف Male ف Female

Address_____ City_____ State_____ Zip_____

SS#_____ Driver's License # _____

Employer's Name _____ Telephone_____

Address_____ City_____ State_____ Zip_____

Carrier's Name_____ Telephone _____

Address_____ City_____ State_____ Zip_____

Have you retained legal counsel for this injury? ف Yes ف No If yes, give name and address:_____

_____

INJURY DESCRIPTION

Date present injury was received:_____ Time of injury_____ ف AM ف PM Overtime? ف Yes ف No

Who saw the accident? _____ Title_____

Who reported the accident? _____ Title_____

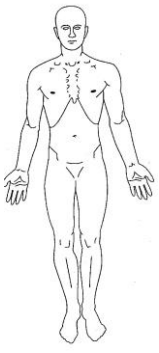
What medical attention was rendered:_____

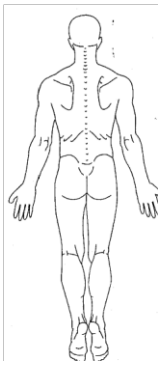
By whom: ف Nurse ف M.D . ف D.O. ف D.C. ف Other employee ف Other _____

Chief Complaint _____

How did the injury occur:_____

_____ Mark





an x on the picture where you continue to have pain, numbness or tingling.

Type of pain: ف Sharp ف Dull ف Throbbing ف Numbness ف Aching ف Shooting ف Burning ف Tingling ف Cramps ف Stiffness ف Swelling ف Other

Symptoms_____

How often do you have this pain?_____

Since the injury, are your symptoms ف Improving ف The Same ف Getting Worse

PRESENT WORK HISTORY

What is the job classification of your normal job?_____

Were you performing your normal job at the time of the accident? ف Yes ف No What shift were you working?

_____

How long have you been at your present job? _____ Has there been any time loss or absenteeism

caused by the job injury? ف Yes ف No If yes, explain:_____

Average work week_____Hours _____Days

PREVIOUS WORK HISTORY

Give job description for each job for the preceding 5 years.

1._____ 3._____

2._____ 4._____

Have you ever applied for workers' compensation benefits before? ف Yes ف No If yes, explain: _____

_____

Was there a time loss from work? ف Yes ف No From _____ to_____ Year_____

Degree recovered now? _____

Legal counsel? ڤ Yes ڤ No If yes, name and address? _____ **JOB**

CONDITION

Type of building _____

Type of floor: ڤ Rough ڤ Smooth ڤ Wood ڤ Concrete ڤ Steel ڤ Other_____

Type of windows: ڤ Open ڤ Closed ڤ No windows

Type of ventilation: ڤ Blower ڤ A/C ڤ Heat ڤ Exhaust ڤ None ڤ Other _____

Type of lighting: ڤ Fluorescent ڤ Overhead ڤ On machine ڤ Other _____

Are you tired when you go home at night? ڤ Yes ڤ No

Do you have any outside jobs? ڤ Yes ڤ No If yes, what?_____

Do you participate in any company-sponsored programs such as exercise, sports ect.? ڤ Yes ڤ No

If yes, describe:_____

If working on a machine, give description_____

Do you use foot or hand levers? ڤ Yes ڤ No Do you work overhead? ڤ Yes ڤ No

Do you have to reach? ڤ Yes ڤ No Where?_____

Movements on the job: do you move to your ڤ Right ڤ Left ڤ Up ڤ Down ڤ Under ڤ Over

Do you pick up or lift? ڤ Yes ڤ No If yes, how much? _____ how often? _____

From where to where? _____

Do you lift from: ڤ Ground ڤ Bench ڤ Platform ڤ Box ڤ Pallet ڤ Other _____

Do you lift in or out of a machine? ڤ Yes ڤ No If working on a machine do you: ڤ Sit ڤ Stand ڤ Kneel

Is your work area cluttered? ڤ Yes ڤ No If yes, with what? _____

Is your work area: ڤ Oily ڤ Dirty ڤ Slippery ڤ Other _____

In your job you push or pull? ڤ Yes ڤ No If yes, give specifics_____

Do you use a cart? ڤ Yes ڤ No Is the cart in good condition? ڤ Yes ڤ No

Total amount of weight being pushed or pulled on a daily basis: _____

OFFICE WORK

If your injury occurred from office work only, please fill out the following:

ڤ sit at desk ڤ walk ڤ stand ڤ stoop ڤ hold ڤ carry ڤ other_____

Give percentage if applicable_____ Do you operate office machinery? ڤ Yes ڤ No

If yes, what type? _____

If your work is at a desk, give specifics of job, computer, typewriter, business machines, phone, ect. :_____

_____

If walking, where to and job classification: _____

Do you carry anything or pick anything up? ڤ Yes ڤ No If yes, what? _____

_____ _____ _____ _____

Patient Signature Date Office Manager Date