MASSAGE APPLICATION

This treatment application is the first step in assisting the doctor in determining if you are a candidate for our non-surgical procedures, therapies and specialized treatment technology. Please answer the following questions honestly and to the best of your knowledge.

CONFIDENTIAL PATIENT INFORMATION

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name_____ Date_____/_____/_____ S/S#_____-_____-_____
First MI Last

Address_____ City_____ State_____ Zip_____

Home Phone _____Cell Phone_____ Work Phone _____

Preferred Contact Method: ❒Home phone ❒Cell phone ❒ Work phone

Sex: ❒ Female ❒ Male Birth Date_____/_____/_____ Email _____

Status: ❒ Minor ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Separated

Occupation_____ Please Explain Duties of Your Work_____

Spouse/ Partner Name _____ Phone_____

Primary Physician _____ Phone Number _____

Insurance Company _____ Claims Address _____

ID Number _____Group Number _____

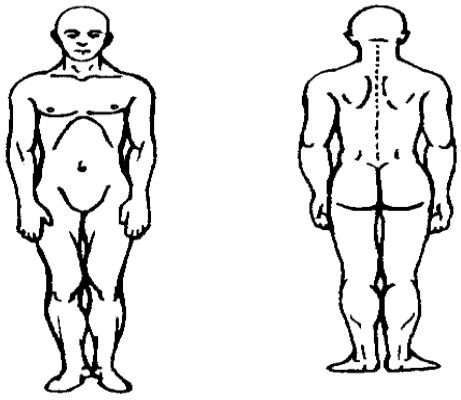
PLEASE LIST YOUR CURRENT PROBLEMS OR COMPLAINTS: (Chief complaint or present illness)

1) _____ 2) _____ 3) _____ 4) _____

What % of the day do these symptoms bother you? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= ^^^^^
Shooting	= →
Other_____	= ***



Please circle the appropriate number(s) for the intensity of your pain and the appropriate letter(s) for the frequency of the pain.

O = Occasional (0-25% of the time) **I = Intermittent** (26-50%)
F = Frequent (51-75%) **C = Constant** (76-100%)

Area of Pain / Symptom & Intensity	Normal	Minimal	Slight			Moderate			Severe			Frequency			
												25%	50%	75%	100%
Neck		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Middle Back		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Lower Back		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Hips L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Shoulders L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Arms L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Hands L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Legs L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Feet L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Other:		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Other:		1	2	3	4	5	6	7	8	9	10	O	I	F	C

Is it worse in the morning or as the day progresses? _____

Does anything relieve your pain?_____

What activities/movements are guaranteed to make it worse? _____

What positions are difficult? ❒Sitting ❒Standing ❒Walking ❒Bending – Direction? _____ ❒Lying Down

❒Other _____

Describe on the scale how the pain has affected your work & activity (both inside and outside the home, and housework)

0 none 1 2 3 4 5 moderate 6 7 8 9 10 extremely

In General, how would you rate your overall health right now? Excellent Very Good Good Fair Poor

Please describe any other activities/hobbies that are restricted due to these symptoms?_____

_____

When did you first notice these symptoms?_____ Is the condition getting worse? ❒ No ❒ Yes

Have you had this problem before? ❒ No ❒ Yes, When?_____

Have you had an injury or fall? ❒ No ❒ Yes, Describe_____

Have you had a Car Accident? ❒ No ❒ Yes, When?_____

Was anyone else in the car with you? ❒ No ❒ Yes, Who?_____

Have you had a work injury? ❒ No ❒ Yes, When?_____

Have you had Lab tests or Xray's for this condition? ❒ No ❒ Yes Where? _____ When? _____

What kinds of treatments have you received for the above condition **(your chief complaint)?**

Epidural: How Many _____ When(approx) _____
Physical Therapy: How Long _____ When _____
Surgery: Type_____ When _____
Type_____ When _____
Other Care: _____ When _____
_____ When _____

Did any of these treatments work? If so, which one(s)? For how long?

_____

_____

Please List **ALL** current medications, the condition it's related to, and the dosage (Only list supplements that are prescribed by your physician):

NAME: _____ CONDITION: _____ DOSAGE: _____
NAME: _____ CONDITION: _____ DOSAGE: _____
NAME: _____ CONDITION: _____ DOSAGE: _____
NAME: _____ CONDITION: _____ DOSAGE: _____
NAME: _____ CONDITION: _____ DOSAGE: _____
NAME: _____ CONDITION: _____ DOSAGE: _____
NAME: _____ CONDITION: _____ DOSAGE: _____

If more space is needed, please use the back of this application and indicate here

Medications one back; □ yes □ no

Would you consider this problem (circle one):

MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but definitely causing limitations)
SEVERE (Causing significant limitations and/or concern)
EXTREME (Causing near constant (> 80% of the time) limitations)

I _____, have completed all questions honestly and to the best of my knowledge. I have read and understand the cancellation, late arrival, and insurance policies.

Signature _____ Date _____