

Massage Therapy Registration

The information you provide is confidential and will not be reproduced or shared without your permission unless permitted by law.

First name _____ MI _____ Last name _____

Gender _____ Birth date _____ Drivers license # _____ State: _____

Home address _____ City _____ State _____ Zip _____

Home phone # _____ Mobile /Voice mail # _____

Your occupation _____ Your work status [circle one] Full time Part time

Your employer _____ Work phone # _____

Employer address _____ City _____ State _____ Zip _____

[circle one] Spouse, Partner or Parent name _____ Their phone # _____

Emergency contact person _____ Their phone # _____

Who referred you or how did you hear about this office? _____

Who is filling out this questionnaire? _____ Relationship to patient: _____

Your Primary Care Physician _____ Phone# or Location _____

Reason for your office visit: *Please summarize why you are visiting our office. You may indicate more than one health concern.*

What do you think caused your current condition? [circle below] *When did it begin?* _____

Auto accident Other accident or injury Work injury Illness Congenital condition Unknown

Has another doctor treated you for your current condition? [circle one] Yes No *Still treating?* [circle one] Yes No

Name of doctor _____ Phone# or Location _____

Have x-rays or MRI films been taken for your current condition? [circle one] Yes No *When?* _____

What other tests have been done to diagnose or monitor your current condition? _____

Please list all medicines you are taking even if they are over-the-counter drugs, herbs or vitamins:

<i>Name</i>	<i>Why do you take it?</i>	<i>What dosage?</i>	<i>Taken for how long?</i>
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Are you allergic to anything (lotion, oil, fabric, detergent)? [circle one] Yes No *If YES, please explain:* _____

Is there anything else you think your health care provider should know? _____

Signature _____ Date _____

Health History

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Personal History

Name _____ Date of Birth _____ Age _____

[circle one] Right handed Left handed Ambidextrous Your HEIGHT: _____ feet _____ inches

Your current WEIGHT: _____ pounds Your normal WEIGHT: _____ pounds

Have you recently gained or lost a significant amount of weight? [circle one] Yes No If YES, how much and over what time period? _____

Female patients, please answer the following questions:

Are you pregnant, or do you have any reason to believe that you could be pregnant? [circle one] Yes No

Number of children _____ Number of pregnancies _____ Number of births _____

Social History Please check the appropriate column if any of the following apply to you:

PAST	PRESENT		
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	Per day _____ or per week _____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	Per day _____ or per week _____
<input type="checkbox"/>	<input type="checkbox"/>	Caffeinated drinks	per day _____ or per week _____
<input type="checkbox"/>	<input type="checkbox"/>	Decaffeinated coffee	per day _____ or per week _____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs and related substances	

Past Health History

PRIOR INJURIES

Please list all major past injuries, even if you never received medical care

INJURY DATE OCCURRED WORK RELATED [yes or no] DOES THE CONDITION RECUR [yes or no]

PRIOR ADULT ILLNESSES

Please list all serious illnesses, such as ASTHMA, CANCER, DIABETES, HEART DISEASE, HEPATITIS, HIGH BLOOD PRESSURE, HIV INFECTION, SEIZURES, SICKLE CELL ANEMIA, TUBERCULOSIS.

DATE DIAGNOSIS TREATMENT GIVEN ANY REMAINING PROBLEMS?

PRIOR SURGERIES & HOSPITALIZATIONS

Please list all major surgeries/ operations and times you were hospitalized, even if you never had surgery

DATE TYPE OF SURGERY OR CAUSE OF HOSPITALIZATION ANY COMPLICATIONS? ANY REMAINING PROBLEMS?

Family History Please tell us about your birth parents and blood relatives if this information is available to you

Mother is [circle one] LIVING DECEASED Age _____ Cause of death _____

Father is [circle one] LIVING DECEASED Age _____ Cause of death _____

Please check the appropriate column if any of the following apply now or in the past to your blood relatives

- | | |
|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes mellitus |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Anemia, blood, bleeding disorders | <input type="checkbox"/> Inherited disorder _____ |

Your Symptoms List Please check the appropriate column for symptoms you have experienced before (PAST) or for symptoms you currently experience (PRESENT)

- | PAST | PRESENT | | PAST | PRESENT | |
|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | General fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Skin rash, dermatitis, eczema |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache | <input type="checkbox"/> | <input type="checkbox"/> | Chronic sinus problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus, noises in the ear | <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision disturbances | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness, lightheadedness | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular incoordination | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn and/ or indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Generalized muscle pain | <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | TMJ (jaw) pain | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain | <input type="checkbox"/> | <input type="checkbox"/> | Loss of bladder or bowel control |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint swelling | <input type="checkbox"/> | <input type="checkbox"/> | Painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint stiffness | <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder pain | <input type="checkbox"/> | <input type="checkbox"/> | Difficult urination or changes in stream |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm pain | <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow pain | <input type="checkbox"/> | <input type="checkbox"/> | Irregular bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist, Hand pain | <input type="checkbox"/> | <input type="checkbox"/> | Irregular menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip pain | <input type="checkbox"/> | <input type="checkbox"/> | Excessive menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg pain | <input type="checkbox"/> | <input type="checkbox"/> | Breast tenderness and/ or lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee pain | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle, foot pain | <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Enlarged lymph nodes, glands | <input type="checkbox"/> | <input type="checkbox"/> | ED |

Signature _____

Date _____