Advanced Motion Therapeutic Massage, Inc.

Patient Information and Medical History

Name: ____ D.O.B. _________

In Case of Emergency __________________________________ Phone: _______________

E-Mail Address: ____

Referring Physician: ____________________________________ Phone: _______________

Present Symptoms (Chief Complaint?) ____
____
____

When did you first notice major complaints? (Approx. period of onset- illness /injury) ___________
____

Have you ever received physical, occupational, speech or massage therapy? Yes or No
IF yes, what, when and where (Be specific) ____
____
____

What activities aggravate the condition? ____
____
____

Please state your goals for treatment: ____
____
____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Yes or No: Do you experience frequent headaches? ____________________________________

Yes or No: Are you pregnant? ____

Yes or No: Do you have diabetes? ____

Yes or No: Do you suffer from back pain? ____

Yes or No: Do you suffer from joint swelling? _______________________________________

Yes or No: Do you have any contagious diseases? ____________________________________

Yes or No: Do you bruise easily? ____

Yes or No: Do you have any allergies? ____

Yes or No: Do you have any difficulty with your speech or language? ______________________

Yes or No: Do people ever have trouble understanding you? ______________________________

Yes or No: Have you ever had any difficulties with chewing or swallowing? __________________

Yes or No: Are you wearing contact lenses? ____

Yes or No: Have you ever had surgery?(When/What) ____________________________________
____
____

Yes or No: Do you suffer from arthritis? (What type)_______________________________________

Yes or No: Do you have osteoporosis? ____

Yes or No: Do you have varicose veins? ____

Yes or No: Do you suffer from epilepsy or seizures? ______________________________________

Yes or No: Do you have cardiac or circulatory problems? __________________________________

Yes or No: Do you have tension or soreness in a specific area? ______________________________

Yes or No: Do you have high blood pressure? ____

Yes or No: Are you taking medication? What? ____
____
____

Yes or No: Have you had any broken bones in the past two years? ___________________________

Yes or No: Have you been in an accident or suffered any injuries in the past two years? _________

____

Yes or No: Are you sensitive to touch or pressure in any area? _____________________________

Yes or No: Do you have numbness or stabbing pains anywhere ______________________________

Yes or No: Do you have any other medical condition I should be aware of? ____________________

Comments: ____

Consent to treatment: By my signature below, I authorize Advanced Motion Therapeutic Massage, Inc. to administer therapy techniques as they deem necessary.

Patient Signature: ____ Date: ___________________

Consent to Treatment of Minor: By my signature below, I hereby authorize Advanced Motion Therapeutic Massage, Inc to administer therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian ________________________________ Date: ____________________