Chiropractic Care Center NW, P.S., Inc.
1905 S.E. 192nd Ave., Suite 111- Camas, WA 98607
Tel: (360)954-5111 * Fax: (360)954-5413

Massage Therapist: _____

HEALTH INFORMATION

Patient Name _____ Date _____

Date of Injury _____ Date Of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Email _____

Employer _____

Type of Work _____

Emergency Contact _____

Relation _____ Phone _____

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 _____

Current Health Information

Primary Area of Complaint: _____

How would you describe this pain?

☐ Mild ☐ Moderate ☐ Disabling

☐ Constant ☐ Intermittent

Symptoms: ☐ Increase with activity

☐ Decrease with activity

☐ Getting worse ☐ Getting better ☐ No change

Treatments received _____

Secondary Area of Complaint: _____

How would you describe this pain?

☐ Mild ☐ Moderate ☐ Disabling

☐ Constant ☐ Intermittent

Symptoms: ☐ Increase with activity

☐ Decrease with activity

☐ Getting worse ☐ Getting better ☐ No change

Treatments received _____

List Daily Activities Limited By Condition

Work _____

Home/Family _____

Sleep _____

Self-care _____

Social/Recreation _____

List Self Care Routines

How do you reduce stress? _____

Pain? _____

List any current medication (including pain relievers & herbal remedies) _____

Have you ever received massage therapy before?

(circle one) **Yes** **No**

If yes, frequency _____

Date of last massage _____

What are your goals for receiving massage therapy?

Health History

List and explain. Include dates and treatments received.

Surgeries _____

Injuries _____

Major illnesses _____

Patient Name: Date Of Birth: Date:

HEALTH INFORMATION continued

Check all *current and previous* conditions.

General

current	past	n/a	
□	□	□	Headaches
□	□	□	Pain
□	□	□	Sleep Problems
□	□	□	Fatigue
□	□	□	Infections
□	□	□	Fever
□	□	□	Sinus problems
□	□	□	Other

Skin Conditions

current	past	n/a	
□	□	□	Rashes
□	□	□	Athlete's foot
□	□	□	Allergies (please explain)_____
□	□	□	Other

Muscles & Joints

current	past	n/a	
□	□	□	Rheumatoid Arthritis
□	□	□	Osteoarthritis
□	□	□	Osteoporosis
□	□	□	Scoliosis
□	□	□	Disc Problems
□	□	□	Spinal Problems
□	□	□	Lupus
□	□	□	TMJ/Jaw Pain
□	□	□	Spasms/Cramps
□	□	□	Sprains/Strains
□	□	□	Tendonitis
□	□	□	Bursitis
□	□	□	Stiff Joints
□	□	□	Weak Muscles
□	□	□	Sore Muscles
□	□	□	Neck/Shoulder/ Arm Pain
□	□	□	Low Back/Hip/ Leg Pain
□	□	□	Other_____

_____

Nervous System

current	past	n/a	
□	□	□	Head Injuries
□	□	□	Dizziness
□	□	□	Memory Loss
□	□	□	Numbness or Tingling
□	□	□	Sciatica
□	□	□	Shooting pain
□	□	□	Chronic pain
□	□	□	Depression
□	□	□	other_____ _____

Respiratory/Cardiovascular

current	past	n/a	
□	□	□	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
□	□	□	Other _____

Allergies

current	past	n/a	
□	□	□	Scents/Lotions
□	□	□	Detergents
□	□	□	Other_____ _____

Digestive/Elimination System

current	past	n/a	
□	□	□	Bowel problems
□	□	□	Gas/Bloating
□	□	□	Bladder/Kidney Prostate
□	□	□	Abdominal Pain
□	□	□	Other_____ _____

Endocrine System

current	past	n/a	
□	□	□	Thyroid
□	□	□	Diabetes

Reproductive System

current	past	n/a	
□	□	□	Pregnancy
□	□	□	Painful Menses
□	□	□	Fibrotic cysts

Habits

current	past	n/a	
□	□	□	Tobacco
□	□	□	Alcohol
□	□	□	Drugs
□	□	□	Coffee/Soda

Contract for Care

I agree 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. 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***_____