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

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Date of Injury	Massage Therapist:						
Date of Injury	HEALTH INFORM	ATION					
Address List Daily Activities Limited By Condition Address Vork City State Zip Home/Family Home Phone Cell Email Selep Email Selep Employer Social/Recreation Type of Work List Self Care Routines Emergency Contact List Self Care Routines Relation Phone PRIMARY HEALTH CARE PROVIDER Pain? Name List any current medication (including pain relievers & herbal remedies) Phone Fax I give my massage therapist permission to consult with my health care providers regarding my health and treatment. Have you ever received massage therapy before? Comments Date If yes, frequency Date Date If yes, frequency Date of last massage Date Date of last massage Initials Date Disabling List and explain. Include dates and treatments Ymptoms: Increase with activity Surgeries Injuries Getting worse Getting better No change Major illnesses Treatments received				Date			
Address	Date of Injury			Date Of Birth			
CityStateCellSleep Home/Family							
CityStateCellSleep Home/Family	Address			Work			
Email Self-care Employer Social/Recreation Type of Work Emergency Contact Ist Self Care Routines Relation Phone List Self Care Routines Relation Phone How do you reduce stress?	City	State Z	Zip	Home/Family			
Email Self-care Employer Social/Recreation Type of Work Emergency Contact Ist Self Care Routines Relation Phone List Self Care Routines Relation Phone How do you reduce stress?	Home Phone	Cell		Sleep			
Type of Work	Email			Self-care			
Emergency Contact	Employer			Social/Recreation			
Emergency Contact	Type of Work						
PRIMARY HEALTH CARE PROVIDER Name Name Name Address City/State/Zip Phone	Emergency Contact			List Self Care Routines			
Name	Relation	Phone		How do you reduce stress?			
Address	PRIMARY HEALTH CARE PROVIDER			Pain?			
City/State/Zip Phone Fax I give my massage therapist permission to consult with my health care providers regarding my health and treatment. Comments Comments Date Initials Initials Date Initials Initials Date Initials Intermittent Stand Int							
Phone				List any current medication (including pain relievers			
I give my massage therapist permission to consult with my health care providers regarding my health and treatment. Image: Comments	City/State/Zip			& herbal remedies)			
I give my massage therapist permission to consult with my health care providers regarding my health and treatment. Have you ever received massage therapy before? Comments	Phone	Fax					
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Comments							
Initials Date If yes, frequency Date of last massage Current Health Information Date of last massage Date of last massage Date of last massage Primary Area of Complaint:	-						
Current Health Information Date of last massage							
Current Health Information What are your goals for receiving massage therapy? Primary Area of Complaint:	Initials	Date					
Primary Area of Complaint:							
How would you describe this pain? Mild Moderate Disabling Health History Constant Intermittent List and explain. Include dates and treatments Symptoms: Increase with activity received. Decrease with activity Surgeries Injuries Getting worse Getting better No change Injuries <i>Treatments received</i> Voltage Major illnesses Major illnesses How would you describe this pain? Mild Moderate Disabling Constant Intermittent Symptoms: Increase with activity Symptoms: Intermittent Disabling	Current Health Info	rmation		What are your goals for receiving massage therapy?			
MildModerateDisablingHealth HistoryConstantIntermittentList and explain. Include dates and treatmentsSymptoms:Increase with activityreceived.Decrease with activitySurgeriesGetting worseGetting betterNo changeTreatments receivedInjuriesInjuriesSecondary Area of Complaint:How would you describe this pain?Major illnessesMildModerateDisablingConstantIntermittentSymptoms:Increase with activityDecrease with activityList and explain. Include dates and treatments	•	-					
Constant Intermittent Symptoms: Increase with activity Decrease with activity Surgeries Getting worse Getting better No change Injuries Treatments received Injuries Secondary Area of Complaint: How would you describe this pain? Mild Moderate Disabling Constant Intermittent Symptoms: Increase with activity Decrease with activity	How would you descr	ribe this pain?					
Symptoms: Increase with activity received. Decrease with activity Surgeries Getting worse Getting better No change Injuries Treatments received Injuries Secondary Area of Complaint: Major illnesses Major illnesses Major illnesses Constant Intermittent Symptoms: Increase with activity Decrease with activity Decrease with activity	\Box Mild	□ Moderate	□ Disabling				
Decrease with activity Surgeries Getting worse Getting better No change Injuries Treatments received Injuries Secondary Area of Complaint: Major illnesses How would you describe this pain? Major illnesses Mild Moderate Onstant Intermittent Symptoms: Increase with activity Decrease with activity	□ Constant			List and explain. Include dates and treatments			
Getting worse Getting better <i>Treatments received</i> Injuries Injuries Major illnesses Major illnesses Major illnesses Major illnesses	Symptoms:	□ Increase with acti	vity	received.			
Treatments received Injuries Secondary Area of Complaint: Major illnesses How would you describe this pain? Major illnesses Mild Moderate Onstant Intermittent Symptoms: Increase with activity Decrease with activity		\Box Decrease with ac	tivity	Surgeries			
Secondary Area of Complaint:	□ Getting worse	□ Getting better	□ No change				
How would you describe this pain? Mild Moderate Disabling Constant Intermittent Symptoms: Increase with activity Decrease with activity	Treatments received	_		Injuries			
How would you describe this pain? Mild Moderate Disabling Constant Intermittent Symptoms: Increase with activity Decrease with activity	Secondary Area of Complaint:			Major illnesses			
Mild Moderate Onstant Intermittent Symptoms: Increase with activity Decrease with activity							
Constant Intermittent Symptoms: Increase with activity Decrease with activity	•	*	□ Disabling				
Symptoms: Increase with activity Decrease with activity 	□ Constant		C				
□ Decrease with activity			vitv				
·	- J		•				
	Getting worse		•				
Treatments received	*						

Patient Name:

HEALTH INFORMATION continued

Check all *current and previous* conditions.

<u>General</u>		Ĩ	Nervous	<u>Nervous System</u>		<u>Allergies</u>			
current	past	n/a	current	past	n/a	current	past	n/a	
		□ Headaches			Head Injuries			□ Scents/Lotions	
		🗆 Pain			Dizziness			□ Detergents	
		Sleep Problems			□ Memory Loss			□ Other	
		Fatigue			□ Numbness or				
		□ Infections			Tingling				
		□ Fever		□ □ □ Sciatica		Digestiv	Digestive/Elimination System		
		Sinus problems			□ Shooting pain	current	past	n/a	
		□ Other			Chronic pain			□ Bowel problems	
					□ Depression			Gas/Bloating	
Skin Co	nditio	<u>ns</u>			□ other			□ Bladder/Kidney	
current	past	n/a						Prostate	
		□ Rashes						Abdominal Pain	
		□ Athlete's foot	<u>Respira</u>	tory/C	Cardiovascular			□ Other	
		□ Allergies (please	current	past	n/a				
explain)					Heart Disease				
		□ Other			□ Blood Clots	Endocr	ine Sys	stem	
					□ Stroke	current	past	n/a	
Muscles	& Joi	<u>nts</u>			Lymphadema			Thyroid	
current	past	n/a			□ High/Low Blood			□ Diabetes	
		Rheumatoid			pressure				
		Arthritis			Irregular Heart	<u>Reproductive System</u>			
		Osteoarthritis			Beat	current	past	n/a	
		Osteoporosis			Poor Circulation			Pregnancy	
		Scoliosis			□ Swollen Ankles			D Painful Menses	
		Disc Problems			□ Varicose Veins			Fibrotic cysts	
		Spinal Problems			Chest Pain				
		Lupus			□ Shortness of	<u>Habits</u>			
		□ TMJ/Jaw Pain			breath	current	past	n/a	
		□ Spasms/Cramps			□ Asthma			Tobacco	
		□ Sprains/Strains			Other			Alcohol	
		□ Tendonitis	□ □ □ Drugs						
		Bursitis	Contrac	t for (Care			□ Coffee/Soda	
		Stiff Joints	I agree to participate fully as a member of my health care team.						
		Weak Muscles	I will make sound choices regarding my treatment plan based on the information						
		□ Sore Muscles	provided by my massage therapist. I promise to inform my practitioner any time I						
		□ Neck/Shoulder/	feel my well-being is threatened or compromised. I expect my massage therapist						
		Arm Pain			and effective treatment		•		
		□ Low Back/Hip/	Consent						
		Leg Pain	It is my	choice	to receive massage the	rapy and I	give m	y consent to receive	
		□ Other	treatment. I have reported all health conditions that I am aware of and will inform						
					r of any changes in my l				
			• •					Date	

Date Of Birth: