PROMASSAGE
INTEGRATIVE HEALTH SOLUTIONS

Tel: (615) 448-6446
313 Bluebird Drive Suite B
Goodlettsville, TN 37072
www.promassageihs.com

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best time/place to contact you:	
Date of birth: **Age:**	**No. of children:**
Pregnant? **Yes** ☐ **No** ☐	**Height:** **Weight:**
Marital status: **M S W D**	**Spouse/guardian name:**
Occupation:	**Employer's name & address:**
Name of person responsible for account:	
Emergency Contact Name:	**Relationship:**
Phone Number:	

How did you hear about us? _____
Have you received massage before?_____
Do you get regular massage? If so how often?_____

Addressing What Brought You Into This Office: *If you have no symptoms or complaints and are here for Massage Wellness Services, please skip to the* ***"General Health History"****.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	Did this condition exist before your accident?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Describe your symptoms (check ALL that apply): ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Achy ☐ Shooting ☐ Tingling
☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Radiating Pain Where does it Radiate to?_____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐
What have you done for this condition? Was it of benefit? _____
_____
I do (do not) have a family history of this or similar symptoms (Please explain): _____
_____
Which activities aggravate your condition? _____
_____
Does anything relieve this problem? _____
_____
How often do you experience your symptoms? ☐ Constantly (**76-100**% of the day) ☐ Frequently (**51-75**% of the day)
☐ Occasionally (**26-50**% of the day ☐ Intermittently (**0-25**% of the day)
Is there a specific time of the day or night which your symptoms occur? ☐ YES ☐ NO
If yes, when? _____

Other doctors you have seen for this condition:

“Limited Scope” Chiropractor (focuses mainly on neck and back pain)	☐
“Wellness” Chiropractor (focuses on health and well-being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Other (please describe)	☐

Doctor’s details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
What did they do?	Did it Help?

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

General Health History *Often times, accumulation of life’s stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!*

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐ If yes, how long have your been wearing them?_____
Do you now or did you as a child prefer to sit on one leg?? ☐ No ☐ Yes

Current Medicines and Supplements

List Type of Medications and/or supplements you are taking:
☐ Anxiety ☐ Muscle Relaxers ☐ Pain Killers ☐ Insulin ☐ Birth control ☐ Cardiovascular
☐ Allergy ☐ Seizure ☐ Other:

_____

_____

List any Allergies:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Molds ☐ Nuts
☐ Penicillin ☐ Rubber ☐ Ragweed/Pollen ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat
☐ Other: _____

Past Health History

Please mark the following conditions you may have had or have now

☐ Alcoholism	☐ Allergies	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Fibromyalgia
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

Other (please explain) _____
_____

Jaw/Facial Pain

Do you have TMJ disorder? ☐ No ☐ Yes
Do you have jaw pain associated with chewing or yawning? ☐ No ☐ Yes
Do you clench or grind your teeth? ☐ No ☐ Yes
Do you wear a night guard or mouth splint? ☐ No ☐ Yes

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. _____
   b. _____
   c. _____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
   c. _____
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

Sleep

What position do you most often sleep in? (circle)
Back Side Stomach Arms Overhead half-stomach/half side Fetal position Pets in bed Spooning with partner

If you sleep on your back:
Do you use pillows under the knees? ☐ No ☐ Yes

If you sleep on your side:
Do you use any pillows between the legs? ☐ No ☐ Yes Do you use any pillows at the chest? ☐ No ☐ Yes

How often do you sleep in each position? _____ How many hours of sleep do you typically get? _____
Are there any reasons you sleep in these positions? _____
Do you have difficulty falling asleep? ☐ No ☐ Yes Do you wake up often in the middle of your sleep? ☐ No ☐ Yes
Do you wake up feeling tired? ☐ No ☐ Yes

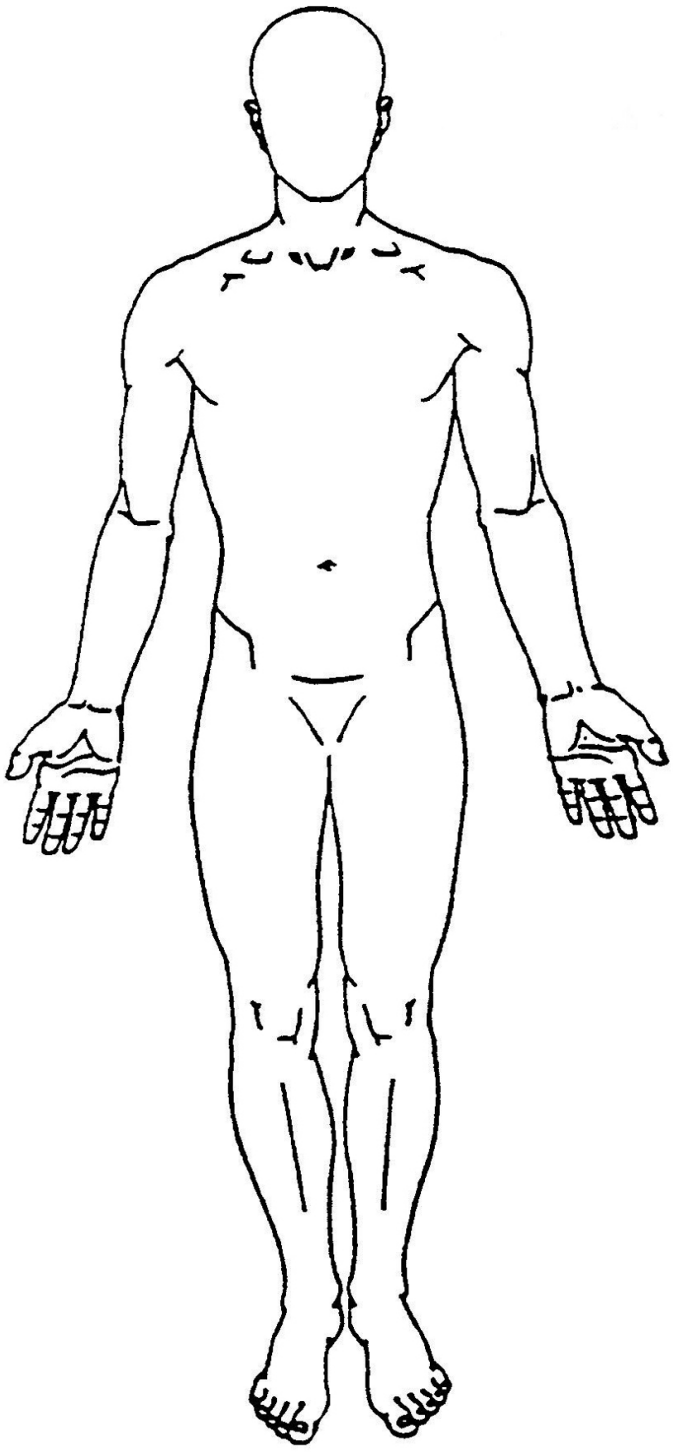
Is there anything else which may help to better understand you which has not been discussed?
_____
_____
_____
_____

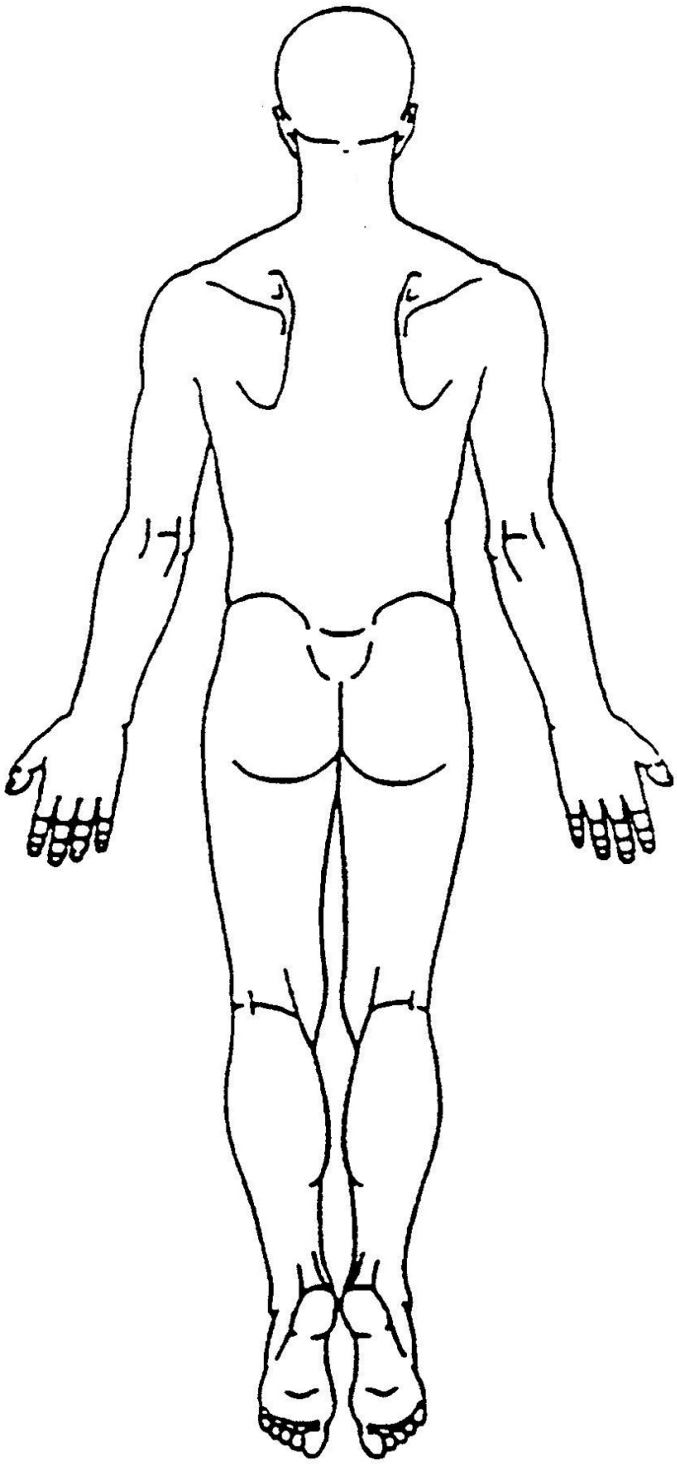
PAIN DRAWING

Patient Name _____**Date**_____

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas.

A = Ache **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing





Subjective & Objective Numerical Outcome Measure Assessment

Informed Consent for Massage Therapy

I hereby request and consent to the performance of massage therapy on me (or on the patient named below for whom I am legally responsible) by the licensed massage therapists at ProMassage Integrative Health Solutions. I understand I have the following rights and responsibilities:

- I have the right to control the amount of pressure applied.
- I have the right to my comfort in the area of temperature, music, lighting, table positioning and draping technique for my highest comfort level.
- I have the right to talk or not to talk, share or not share about my internal experiences.
- I have the right to be treated with respect and without judgment: physically, emotionally, and spiritually.
- I have the right to experience safety and comfort in respect to areas of the body touched, amount of clothing worn/removed and draping techniques used.
- If the session includes the removal of any clothing, I have the right to dress and undress in privacy.

Client responsibilities:
I will let my practitioner know of all relevant medical issues prior to the start of our session. I agree to let my practitioner know if touch in any area is uncomfortable or needs to be modified for my comfort.

I understand that the touch or manner of communication of the licensed massage therapist is never intended to be sexual in nature. If at any time, I feel the touch, manner or language of the therapist is inappropriate for me, I will immediately inform the practitioner. Inappropriate behavior advances, or language towards the practitioner are grounds for termination of the session resulting in full payment for the session.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involved the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

Cancelation Policy: I understand that I must provide a minimum of 24 hours' notice to cancel or change an appointment. Failure to abide by this policy will result in a charge equal to half of the appointment fee being applied to the credit card we have on file or being applied to your account.

There are no refunds on gift cards or packages/series that are bought.

I have read, or have had read to me, the above consent. I have had an opportunity to ask questions about its content and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have completed this health form to the best of my knowledge.

Patient Name_____

Signature_____Date_____

Reviewed by: _____on:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Printed Patient Name (please print neatly) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Please list below the names and relationships of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

_____ _____