PROMASSAGE
INTEGRATIVE HEALTH SOLUTIONS

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FSM INTAKE

Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. These questions will help to identify underlying causes of symptoms and will also assist us to formulate a treatment plan

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best time/place to contact you:	**SS#**
Date of birth: **Age:**	**No. of children:**
Any Chance of Pregnancy? **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? _____

If from a client please give us their name so they receive the referral.

1. Please rank current/ongoing problems by priority and fill in the other boxes as completely as possible:

Describe top three Health Issues	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain or sensation is present
1.					
2.					
3.					

2. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister

   _____
   _____
   _____

3. Do you have any pets or farm animals? Yes_____No_____
   If yes, where do they live? 1. _____indoors 2. _____Outdoors 3. _____Both indoors and outdoors

4. Have you lived or traveled outside of the United States? Yes____No_____
   If so, when and where? _____
   _____

5. Have you or your family recently experienced any major life changes? Yes____No_____
   If yes, please comment: _____
   _____

6. Have you experienced any major losses in life? Yes____No_____
   If so, please comment: _____
   _____

7. Have you experienced any emotional or physical trauma/abuse in yourlifetime? Yes_____No_____
   _____
   _____
   _____

8. How important is religion or spirituality for you and your family's life?
   a. _____not at all important
   b. _____somewhat important
   c. _____extremely important

9. How much time have you lost from work or school in the past year?
   a. _____0-2 days
   b. _____3 –14 days
   c. _____> 15 days

10. Past Medical and Surgical History:

	ILLNESSES	WHEN	COMMENTS
	Anemia		
	Arthritis		
	Asthma		
	Autoimmune Disorder		
	Breast (Fibrocystic, Calcifications, Densities)		
	Bronchitis/Emphysema/Pneumonia		
	Cancer		
	Clotting Defects		
	Childhood Illness (i.e. rheumatic fever, chickenpox, mumps, measles, etc.)		
	Chronic Fatigue Syndrome		
.	Crohn's Disease or Ulcerative Colitis		
	Dental Issues		
	Depression/Anxiety		
	Diabetes (Type 1, Type 2)		
	Eating Disorder (Anorexia, Bulimia)		

Epilepsy, convulsions, or seizures		
Fibromyalgia		
Gallstones		
Gout		
Heart Disease, Attack/Angina/Failure		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Hypermobility		
Irritable bowel		
Kidney stones		
Liver Disease (Hepatitis, Fatty, Other)		
Osteoporosis/Osteopenia		
Sinusitis		
Sleep apnea		
Stroke		
Thyroid disease		
Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
Back injury		
Fracture / Right or Left		
Head injury		
Neck injury		
Other (describe)		
DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
Barium Enema		
Bone Scan		
CAT Scan (Location)		
Chest X-ray		
Colonoscopy/Sigmoidoscopy		
EKG		
MRI		
Thermogram		
Upper GI Series		
Other (describe)		

OPERATIONS	WHEN	COMMENTS
Appendectomy		
Cosmetic Surgery (Location)		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy (Partial or Total)		
Tonsillectomy		
Tubal Ligation		
Vasectomy		
Other (describe)		

11. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

12. How often have you have taken antibiotics?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

13. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

14. Are you allergic to any medications? Yes _____ No _____
If yes, please list with reactions:

_____

_____

_____

15. What medications are you taking now? Include non-prescription drugs.

Medication Name/Dose	Date started	Tolerance/Side Effects
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

16. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

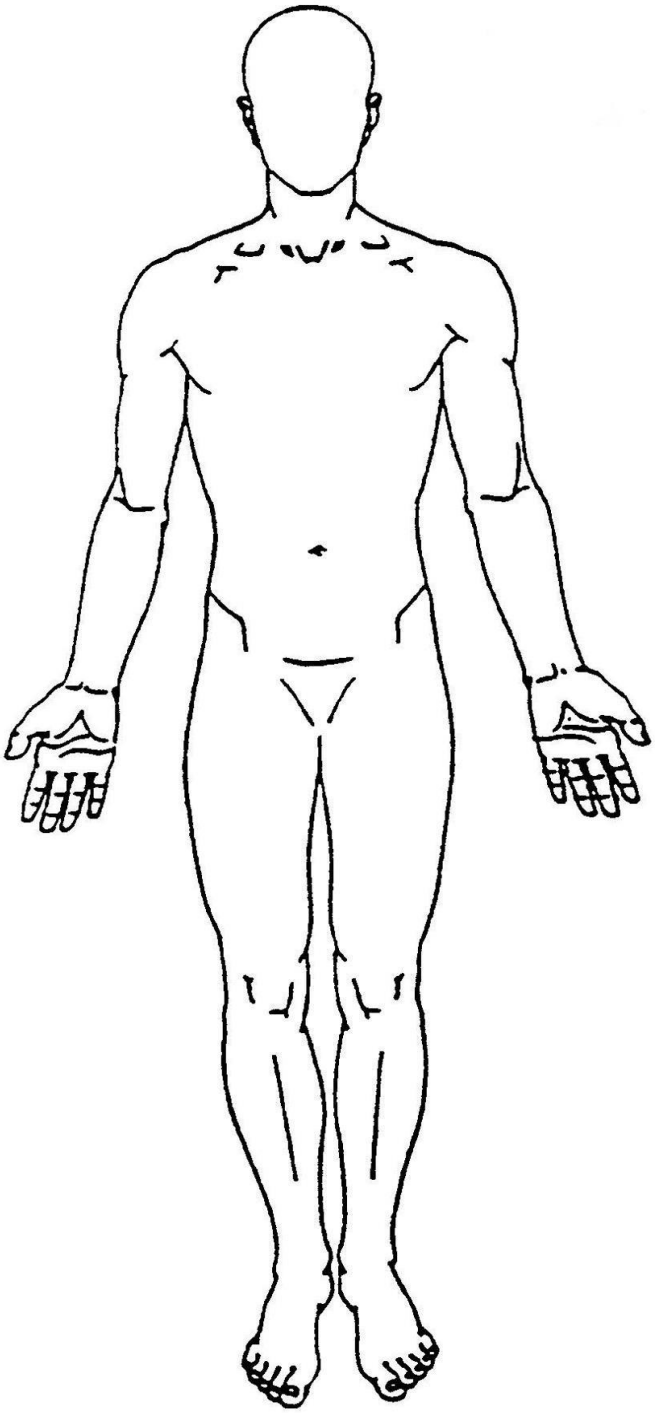
Supplement Name, Dose and Brand	Date started	Effective?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

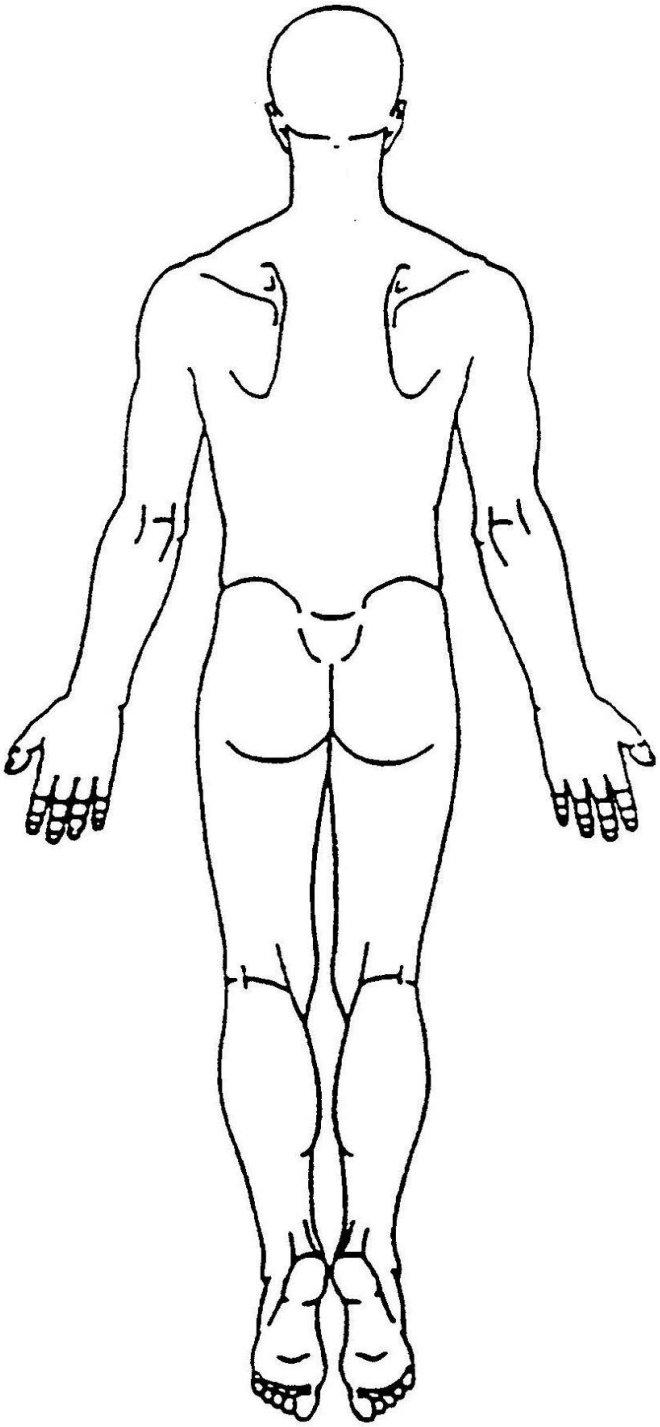
PAIN DRAWING

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





17. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full-term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

18. As a child, were there any foods that you had to avoid because they gave you symptoms?
Yes_____ No_____
If yes, please: name the food and symptom (Example: milk – gas and diarrhea)
_____
_____
_____
_____

19. Are you on a special diet? Yes_____No_____ How long have you been on this diet?_____
_____GFCF _____vegetarian _____other (describe):
_____Diabetic _____vegan _____
_____Dairy restricted _____blood type diet _____

20. Is there anything special about your diet that we should know? Yes_____ No_____
If yes, please explain:
_____

21. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?
Yes_____ No_____
b. If yes, are these symptoms associated with any particular food or supplement(s)?
Yes_____ No_____
c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.
_____
_____

22. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes_____No_____

23. Do you feel much **worse** when you eat a lot of:
_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other _____

24. Do you feel much **better** when you eat a lot of:
_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other _____

_____

No_____

_____

25. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

26. Have you ever had psychotherapy or counseling? Yes____No_____
Currently?_____ Previously?_____If previously, from_____to_____.
What kind? _____
Comments: _____

27. Are you currently, or have you ever been, married? Yes____No_____
If so, when were you married? _____ Spouse's occupation _____
When were you separated? _____ Never_
When were you divorced? _____ Never_
When were you remarried? _____ Never _____ Spouse's occupation _____
Comments: _____

28. Hobbies and leisure activities: _____
_____

29. Do you exercise regularly? Yes____No_____

If so, how many times a week?
1. _____1x
2. _____2x
3. _____3x
4. _____4x or more

When you exercise, how long is each session?
1._____<15 min
2._____16-30 min
3._____31-45 min
4._____> 45 min

What type of exercise is it?
_____Jogging/walking
_____Basketball
_____Home aerobics
_____tennis
_____water sports
_____other _____

FAMILY HISTORY: For each member of your family, follow the grey or white line across the page and check the boxes for:

1. Their present state of health, and
2. Any illnesses they have had.

*(Note: Except for **spouse** , Family refers to **blood** or **natural** relatives.)* **PRINT NAME/AGE BELOW**	Good Health	Poor Health	Deceased/ Cause	Alcoholism	Allergies or Asthma	Alzheimer's or Dementia	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Dis.	Nervous Breakdown	Rheumatism or Arthritis	Other
Father																		
Mother:																		
Brothers/Sisters:																		
Spouse:																		
Child:																		
Child:																		
Child:																		
Child:																		
Paternal relatives (in each box, write in how many affected with condition):																		
Maternal relatives (in each box, write in how many affected with condition):																		

30. Any other family history we should know about? Yes____No_____
    If so, please comment: _____

31. What is the attitude of those close to you about your illness?
    _____Supportive
    _____Non-supportive

32. Please check if these symptoms occur presently or have occurred in the past 6 months. Note location where applicable.

GENERAL:	Mild	Mod-erate	Severe
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Fatigue (AM/PM/Constant)			
Fever			
Flushing			
Heat intolerance			
Insomnia			
Nightmares			
No dream recall			
Weight Gain/Loss			
HEAD, EYES & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye dryness/crusting			
Eye pain			
Eyelid margin redness			
Headache (Migraine or Tension)			
Hearing loss			
Hearing problems			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	Mild	Mod-erate	Severe
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain / redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES:			
Agoraphobia			
Anxiety / panic attacks			
Auditory hallucinations			
Black-out			
Depression / Low Mood			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headed			

MOOD/NERVES, Cont'd:	Mild	Mod-erate	Severe
Mood swings			
Numbness /Tingling			
Obsessive / compulsive			
Other Phobias			
Paranoia			
Seizures			
Suicidal thoughts/Plan			
Tremor/trembling			
Visual hallucinations			
EATING:			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
DIGESTION:			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating			
Blood in stools			
Burping / belching			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Feels full too long after meal			
Farting			

DIGESTION, Cont'd:	Mild	Mod-erate	Severe
Fissures			
Heartburn/Reflux			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Stomach pain			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
SKIN PROBLEMS:			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			

SKIN PROBLEMS, Cont'd:	Mild	Mod-erate	Severe
Eczema			
Hair Loss			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Mole w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			
Wheezing			

SKIN, DRYNESS OF:	Mild	Mod-erate	Severe
Feet cracking /peeling			
Hair dry/loss			
Hands cracking /peeling			
Mouth/throat			
Scalp dandruff			
Other			
LYMPH NODES:			
Neck enlarged/tender			
Other enlarged/tender lymph nodes			
NAILS:			
Bitten			
Brittle / soft			
Curve up / frayed			
Fungus - fingers / toes			
Pitting / ridges			
Ragged cuticles			
Thickening of: Finger nails / toenails			
White spots/lines			

RESPIRATORY:	Mild	Mod-erate	Severe
Bad breath			
Bad odor in nose			
Cough - dry / productive			
Hay fever: Season_____			
Hoarseness			
Nasal / Sinus stuffiness			
Nose bleeds			
Post nasal drip			
Shortness of breath			
Sinus infection			
Snoring			
Sore throat			

CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High/low blood pressure			
Mitral valve prolapse			
Palpitations/Irregular Pulse			
Phlebitis			
Rapid Heart Rate /Tachycardia			
Swollen ankles/feet /hands			
Varicose veins			

URINARY:	Mild	Mod-erate	Severe
Bed wetting			
Blood in urine			
Hesitancy /urgency			
Bladder Infection			
Kidney disease / stones			
Leaking/incontinence			
Nocturia (# times per night _____)			
Pain/burning			
Prostate enlargement			
Prostate infection			
PSA Level Normal?			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Erectile dysfunction /maintaining erections			
AM Erections?			
Infection			
Lumps in testicles			
Poor libido (sex drive)			

FEMALE REPRODUCTIVE:			
Breast cysts / lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Hot Flashes/Night Sweats			
Infertility			
Nipple discharge			
Painful intercourse			
Vaginal discharge			
Vaginal dryness			
Vaginal odor / itch			
Vaginal pain			
Premenstrual: Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Frequency Specific Microcurrent Consent

I,_____authorize the ProMassage Integrative Health Solutions to perform the treatment known as Frequency Specific Microcurrent therapy (FSM). This is a noninvasive means of treating various conditions, including chronic pain. Your practitioner may recommend this treatment for off label uses of this device as there have been studies evolving in the literature supporting new uses. The equipment that we use is classified by the FDA as a TENS unit/device. TENS has not been shown to have any short- or long-term complications to date. However, the possibility that the device may affect some sensitive users in a presently unknown way cannot be overlooked. I understand that FSM involves the use of physiologic (tiny) amounts of electric current (i.e. Millionths of an ampere) applied to the body. I understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. However, I recognize that the chances of success are enhanced by following the directives of my clinician (for example, to be well hydrated on the day of my treatment). There are some people who may not be able to receive FSM therapy, including women who are pregnant and patients using demand type pacemakers. ***Please initial the following statements below:***

_____I am not pregnant,
_____I do not have demand style pacemaker, or any other implanted electronic device that cannot be turned off
_____I do not have any infections.
_____I do not have seizures or epilepsy

I recognize that FSM therapy has potential risks and potential benefits. These risks and benefits are as follows: Potential Risks: FSM has a history of safety and side effects are uncommon. If they do arise, they typically start during or about 90 minutes after treatment and last for a few minutes to a few hours. Side effects are similar to any use of electrical media when applied to the body, such as Ultrasound, EKG, etc., or to having a massage. These include irritation at the site of stimulation, soreness, fatigue, light-headedness, drowsiness or transient weakness. Symptoms may also worsen transiently before improving. Some treatments can result in transient dizziness. Microcurrent/TENS can induce seizures if there is a history of epilepsy.

Potential Benefits: Microcurrent therapy is painless, often increases speed of recovery, and often promotes healing in conditions that have not responded to other treatment. Microcurrent therapy can also lead to resolution of the health concern being treated and the inducement of a greater sense of well-being. The effects are long lasting and occur without the side effects of pharmaceutical drugs. I hereby release ProMassage Integrative Health Solutions from all liability in connection with the FSM therapy I receive. I understand that I am free to discontinue treatment at any time.

I understand this consent form and have had any questions answered by my practitioner.

_____

Patient Name Printed

_____ _____

Patient Signature Date

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 LMT's of ProMassage Integrative Health Solutions.

I understand I may receive massage therapy as part of my treatment plan. In regards to massage therapy 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 therapist the nature and purpose of massage and other procedures. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my licensed massage therapist 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 the full amount 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:_____

PROMASSAGE
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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.

_____ _____

_____ _____

_____ _____

_____ _____