PRO-BODY MASSAGE
justin walsh l.m.p.

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PATIENT INFORMATION

Patient Name ______________________ Date ____________ SS# ______________

Address ______________________ City ______________

State ____________ Zip ____________ E-mail ______________

Sex M ◯ F ◯ Age ______ Birthdate ______________

Married ◯ Widowed ◯ Single ◯ Minor ◯ Separated ◯ Divorced ◯ Partnered for ____ years

Occupation ______________________ Patient Employer/School ______________

Whom may we thank for referring you? ______________________

PHONE NUMBERS

Home Phone ____________ Cellular Phone ____________ Work Phone ____________

Best time to reach you ______________________

In case of emergency, contact:

Name ____________ Realtionship ____________ Home Phone ____________ Other Phone ____________

ACCIDENT INFORMATION

Is this condition due to an accident? Yes ◯ No ◯

Date of accident ______________________

Type of accident: Auto ◯ Work ◯ Home ◯ Other ◯

To whom have you made a report of your accident? Insurance ◯ Employer ◯ Worker Comp. ◯ Other ◯

Attorney Name ______________________ Phone # ______________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________
(name of insurance company)

and assign directly to Pro-Body Massage all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Pro-Body Massage may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
(Signature of Patient, Parent, Guardian, or Personal Representative)

____
(Signature of Patient, Parent, Guardian, or Personal Representative)

PATIENT CONDITION

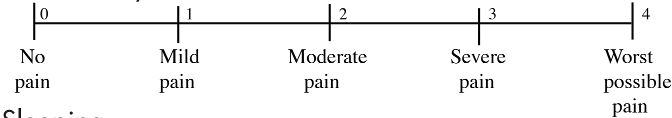
Reason for Visit ______________________________

____

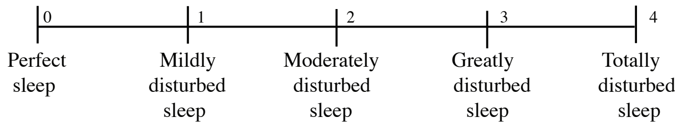
When did your symptoms appear? ______________________________

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please print this out and mark with a pen the number which most closely describes your condition right now.

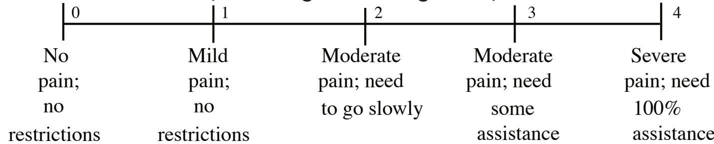
1. Pain Intensity



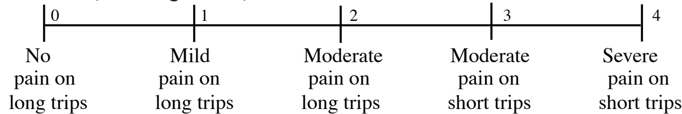
2. Sleeping



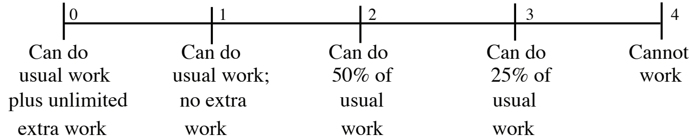
3. Personal Care (washing, dressing, etc.)



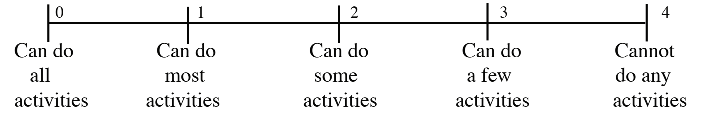
4. Travel (driving, etc.)



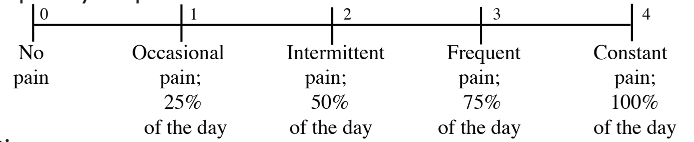
5. Work



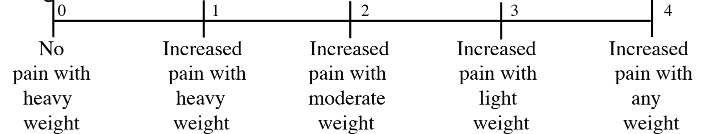
6. Recreation



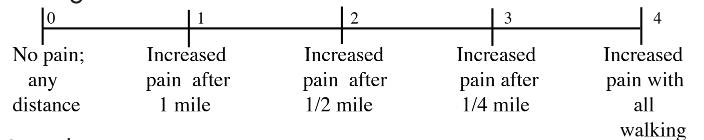
7. Frequency of pain



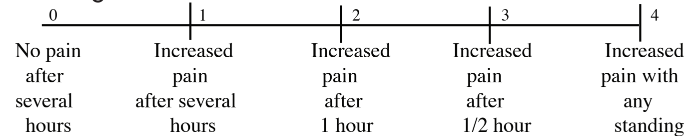
8. Lifting



9. Walking



10. Standing



HEALTH HISTORY

What treatment have you already received for your condition?

Chiropractic Services ◯ Acupuncture ◯ Occupational Therapy ◯ Primary Care Visit ◯

Name and contact information of other specialists who you have seen for this condition

____

____

____

____

____

____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

yes	no	
◯	◯	AIDS/HIV
◯	◯	Alcoholism
◯	◯	Allergy Shots
◯	◯	Anemia
◯	◯	Anorexia
◯	◯	Appendicitis
◯	◯	Arthritis
◯	◯	Asthma
◯	◯	Bleeding Disorders
◯	◯	Breast Lump
◯	◯	Bronchitis
◯	◯	Bullimia
◯	◯	Cancer
◯	◯	Chemical Dependency
◯	◯	Chicken Pox
◯	◯	Diabetes
◯	◯	Emphysema
◯	◯	Epilepsy
◯	◯	Fractures
◯	◯	Glaucoma
◯	◯	Goiter
◯	◯	Gonorrhea
◯	◯	Gout
◯	◯	Heart Disease
◯	◯	Hepatitis
◯	◯	Hernia
◯	◯	Herniated Disk
◯	◯	Herpes
◯	◯	High Cholesterol
◯	◯	Kidney Disease

yes	no	
◯	◯	Liver Disease
◯	◯	Measles
◯	◯	Migraine Headaches
◯	◯	Miscarriage
◯	◯	Mononucleosis
◯	◯	Multiple Sclerosis
◯	◯	Mumps
◯	◯	Osteoporosis
◯	◯	Pacemaker
◯	◯	Parkinson's Disease
◯	◯	Pinched Nerve
◯	◯	Pneumonia
◯	◯	Polio
◯	◯	Prostate Problem
◯	◯	Prosthesis
◯	◯	Psychiatric Care
◯	◯	Rheumatoid Arthritis
◯	◯	Rheumatic Fever
◯	◯	Scarlet Fever
◯	◯	Stroke
◯	◯	Suicide Attempt
◯	◯	Thyroid Problem
◯	◯	Tonsillitis
◯	◯	Tuberculosis
◯	◯	Tumors, Growths
◯	◯	Typhoid Fever
◯	◯	Ulcers
◯	◯	Vaginal Infections
◯	◯	Venereal Disease
◯	◯	Whooping Cough
◯	◯	Other

EXERCISE

None ◯
Moderate ◯
Daily ◯
Heavy ◯

WORK ACTIVITY

Sitting ◯
Standing ◯
Light Labor ◯
Heavy Labor ◯

HABITS

Smoking (Packs/day) ____________
Alcohol (Drinks/wk) ____________
Coffee/Caffeine (Cups/day) ____________

Are you pregnant? Yes ◯ No ◯ Due Date ____________

Describe any injuries/Surgeries you have had:

Falls ____________ (date) ____________
Broken Bones ____________ (date) ____________
Dislocations ____________ (date) ____________
Surgeries ____________ (date) ____________

MEDICATIONS

____
____
____
____

ALLERGIES

____
____
____
____

VITAMINS/HERBS

____
____
____
____

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CANCELLATION POLICY

You have made an appointment at Pro-Body Massage. Each appointment is slotted as 1-hour, including a brief intake to determine a treatment plan which best suits your needs. Please keep in mind that this spot is reserved for you and no other patient. If you find that you will not be able to keep your appointment, please be courteous enough to give notice, so I may offer the time slot to another patient. Appointments cancelled with less than 24 hours notice will be subject to a $25 fee. A patient who arrives more than 10 minutes late for an appointment may be asked to reschedule. Your consideration is appreciated.

I have read the above statement and understand that I am responsible for paying Pro-Body Massage a $25 fee for any appointment missed without at least 24 hours notice.

Signature: ____

Date: ____