Aurora Village Med. Ctr
1207 N. 200th St. Suite 107
Shoreline, WA 98133
(206) 293-2961
Fax (425) 379-2382

E-mail:
naturalbalance@comcast.net

MASSAGE THERAPY PATIENT INFORMATION FORM

Date:_______/_______/________ Date of Accident or Injury:______/_____/_____
(if applicable)

Patient Name:———————————————————- Date of Birth __________________ Age _________
Insurance I.D. Number _______________________ (required for insurance patients) Female ______Male ______
Married ___ Single ____ Other ________ Name of Insurance Company ______________________________________
Claim Number ______________________________ Insurance in Spouse's/Another's Name? Yes ___ No ____
Occupation _____________________________________ Employer ____________________________________
Home Address: ______________________________________ Home Phone ___________________________________
_____________________________________ Work Phone___________________________________
Zip______________________ Cell Phone__________________________________
E-mail Address (home)____

E-mail Address (work)
____

Please list any accidents, injuries, or surgeries (List all traumas no matter how old)
Date:___________Describe:____ Treatment Rec'd__________________________
Date:___________Describe:____Treatment Rec'd__________________________
Date:__________ Describe:____Treatment Rec'd__________________________
Date:__________ Describe:____Treatment Rec'd__________________________

List referring physician/primary doctor:____Phone:__________________________
Medical condition/problem for which referred: ____

Received massage therapy before? ____If yes, how long ago?___________ For what reason? (circle one) relaxation treatment
Received Chiropractic care, past or present?_____Chiropractor ___________________Dates______________________
Are you taking any medications?________ If yes, please list: (include hormones, herbal supplements, allergy meds.)

____

Do you have diabetes/low blood sugar? ______ If yes, have you eaten w/in the past 2 hours? ______
Are you pregnant? ________ If so, how many weeks? __________________

Are you currently experiencing any of the following conditions: Inflammation _____ Cold/flu ______ Fever ______

Infection ______ High blood pressure (140/90 or greater) _______ (If you have any of these, massage is not indicated at this time)

Do you wear contact lenses? ______ (If so, it is recommended you not wear them during massage)

Please describe your current level of physical activity: _____ None _____ Light _____ Medium _____ Heavy
Please describe your exercise regimen____
How often do you exercise?____
Are you currently aware of any tight or uncomfortable areas of your body? _______

If so, where?____

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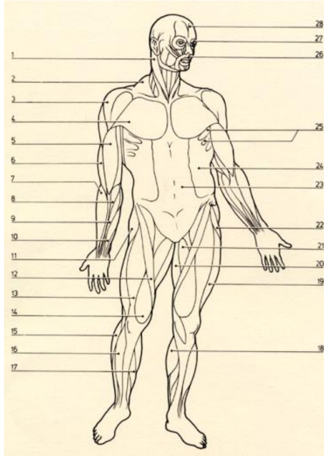
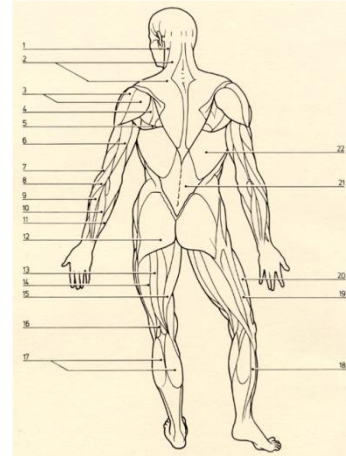
Please indicate by circling on the body what parts of your body are stiff, sore, in pain, etc.





Please indicate "C" for Current or "P" for Past recurrent problems (other than occasional)

Condition		
Allergies	C	P
Anemia	C	P
Arthritis	C	P
Back pain	C	P
Broken bones	C	P
Bursitis	C	P
Cancer	C	P
Carpal tunnel	C	P
Chronic Fatigue Synd.	C	P
Circulation problems	C	P
Colitis	C	P
Constipation	C	P
Diarrhea	C	P
Diabetes	C	P
Digestive problems	C	P
Disc problems	C	P
Diverticulitis	C	P
Eczema	C	P
Fibromyalgia	C	P
Headaches	C	P
Heart ailments	C	P
Hemophilia	C	P
High blood pressure	C	P
Insomnia	C	P
Low blood pressure	C	P
Migraines	C	P
Muscle spasms	C	P
Numbness	C	P
Phlebitis	C	P
Plantar Fasciitis	C	P
Psoriasis	C	P
Rashes	C	P
Ringworm	C	P
Skin allergies	C	P
Sleep disorder/s	C	P
Stiff/Aching joints	C	P
Stiff/Aching Muscles	C	P
Strains/Sprains	C	P
Excess stress	C	P
Stroke/TIA	C	P
Swollen feet/legs	C	P
Tendonitis	C	P
Tingling	C	P
Tumors	C	P
Varicose veins	C	P
Whiplash	C	P
(Women Only)		
Menopause	C	P
Menstrual Cramps	C	P
Excessive bleeding	C	P
Hot flashes	C	P
Irregular Periods	C	P
Itching/Hives	C	P
PMS	C	P

If you need to clarify any of the above conditions, or put others not mentioned above, please do so here:

PLEASE READ AND SIGN THE FOLLOWING:

I understand that the above information is accurate to the best of my knowledge. I agree to the release of information for medical or insurance purposes. I authorize Judy Porter, LMP, or employees of Natural Balance to obtain any information from my primary health care providers concerning my health.

I clearly understand that massage therapy treatments are my personal financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been made in advance.

I also understand that I will be charged for any appointments cancelled with less than 24 hrs. notice, except in cases of illness or unforseen circumstances. Insurance patients who cancel without appropriate notice/circumstances will be personally responsible for the full amount normally charged to the insurance company.

PATIENT SIGNATURE____**Date**________________