INITIAL EVALUATION /ASSESSMENT

PATIENT: ______________________________

Address: ______________________ State: __________ Zip: __________

DATE OF BIRTH: ______________________ HOME PH: ______________________

OCCUPATION: ______________________ WORK PH: ______________________

HOW LONG: ______________________ EMAIL ADDRESS: ______________________

SPOUSE: ______________________ SPOUSE WORK #: ______________________

INSURANCE: NAME OF COMPANY: ______________________

Date of Incident ______________________ GROUP: ______________________

CLAIM / POLICY #: ______________________ REF BY: ______________________

S. S. #: ______________________ ADJUSTER______________________

DOCTOR: ______________________ **ATTORNEY:** ______________________

PHONE #: ______________________ PHONE: ______________________

ADDRESS: ______________________ **ADDRESS:** ______________________

CITY: ______________________ CITY: ______________________

STATE: __________ ZIP: __________ STATE: __________ ZIP: __________

EMPLOYER: ______________________________

COMPANY: ______________________ PHONE: ______________________

SUPERVISOR: ______________________________

ADDRESS: ______________________ CITY: __________ ST: _____ ZIP: __________

NOTIFY/ EMERGENCY: ______________________ PHONE: ______________________

Nearest relative, not living with you? ______________________

Relationship: ______________________ Phone: ______________________

HOW WILL PAYMENT BE MADE?

AUTO INSURANCE: ☐ WORKERS' COMPENSATION: ☐ MAJOR MEDICAL: ☐ CASH: ☐

ATTORNEY LIEN: ☐ CREDIT CARD: ☐ CHECK: ☐ OTHER: ☐ How? ______________________

CREDIT CARD: TYPE: ______________ CARD # ______________________

EXP. DATE: ______________ CV Code: (3 #'s on back or 4#'s front of AMEX ______________

Address used for CC Billing: ______________________ State __________ Zip __________

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- Was this case related to Work ☐ Auto ☐ or Other ☐ Explain ______________________
- How did it happen? ______________________
- If it happened at work, was the employer notified? Yes ☐ No ☐
- Has the insurance company been notified? Yes ☐ No ☐
- Are you presently employed? Yes ☐ No ☐
- Occupation: ______________________
- If work related, are you working for same employer? Yes ☐ No ☐
- Are you presently under a doctor's care? Yes ☐ No ☐
- Have you ever been treated for the same condition? Yes ☐ No ☐
- Were you admitted to the hospital? Yes ☐ No ☐ How long? ______________
- What makes your condition worse? ______________________
- Surgery in past 4 years Yes ☐ No ☐ If yes, Explain: ______________________

  ____

  ____

- Smoke Yes ☐ No ☐ Use alcohol, Yes ☐ No ☐ Tea Yes ☐ No ☐Caffeine Yes ☐ No ☐

  Coffee Yes ☐ No ☐ **Chocolate** Yes ☐ No ☐ **Eat red meats** Yes ☐ No ☐

- If female, are you pregnant Yes ☐ No ☐ Date due:_______ Wear Contacts Yes ☐ NO ☐

- High blood pressure Yes ☐ No ☐ If yes, approximately your latest reading? ________ /__________
- Contagious Diseases Yes ☐ No ☐ If yes, explain ______________________
- Heart Condition Yes ☐ No ☐ If yes, Explain______________________
- Wear Contacts Yes ☐ No ☐
- Varicose Veins Yes ☐ No ☐ Where? ______________________
- Cancer Yes ☐ No ☐ If yes, Location? ______________________

List 3 major health complaints and medications you are taking: (use back of form if necessary)

1. ______________________
2. ______________________
3. ______________________

Medications______________________

Do you have any family history, preexisting conditions or possible medical contraindications that might cause concern or that would affect your present injury, illness or other medical conditions such as diseases, implants, surgeries, etc? YES__ NO ____If YES, please explain: **Use Back of Form**______________________

I hereby grant permission to the massage therapist(s) at this facility to provide massage therapy services to me. I acknowledge that if I am not satisfied with said services I am free to go elsewhere. I have a right to a copy of my medical records if requested. *(I realize that copy charges may apply.)* I understand that I am receiving my physician prescribed health care related massage therapy services by a trained, licensed and/or certified massage therapist. I understand that a massage therapist, under no circumstance, is allowed to diagnose or offer a prognosis of my medical condition.

Patients or Legal Representative: ______________________ Date: ______________

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