Great Lakes Clinical Massage Therapy
Patient Health Record

Please fill out our *confidential* patient health record completely and accurately.

Clinical Massage Therapy is a soft tissue therapy that utilizes deep tissue massage, manual joint mobilization, hot/cold therapy, and therapeutic exercise procedures to reduce, pain, spasm, and inflammation.
If you have any questions, please don't hesitate to ask.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being possible.

ABOUT THE PATIENT

Name: _____

Address: _____

City: _____State: _____Zip: _____

Phone: Home: (___)_____ Cell : (___)_____

Email address: _____

Birthdate: _____ Age: _____ Gender: ❑M ❑ F

Marital Status ❑Married ❑Single ❑Divorced ❑Separated ❑Widowed

Number of Children: _____ Are you a student? ❑Y ❑N

Employer: _____

Type of Work: _____

Work Phone: (____)_____

HOW DID YOU HEAR ABOUT THE OFFICE?

❑Drive By ❑Google ❑Facebook

❑Website ❑Flyer ❑Phone Book

❑Referral: _____

❑Other: _____

Do you have family or friends who are treated here?

❑Yes ❑No

INSURANCE

Will you be using insurance for your care?

❑Yes ❑No

If yes, we will need some additional information about the person who holds the insurance policy. (Please see attached pages.)

EXPERIENCE WITH TREATMENT

Have you had a massage before? ❑Yes ❑No

Approximate date of last visit: _____

Type of Treatment: ❑Clinical ❑Relaxation ❑Other

What were your results? _____

_____

IN AN EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Cell Phone: _(_____)_____

Other Phone: _(_____)_____

REASON FOR THIS VISIT

Tell us about your symptom(s): _____

Is the purpose of this visit related to: ❑Job ❑Sports Injury ❑Auto Accident ❑Home Injury

❑Chronic Discomfort ❑Fall ❑Other, Please explain: _____

If job or auto related, have you made a report of your accident to your employer or insurance agent? ❑Yes ❑ No

When did these symptoms begin? _____

Since they started, have the symptoms: ❑Gotten worse ❑Stayed the same ❑Gotten Better ❑Come & Go

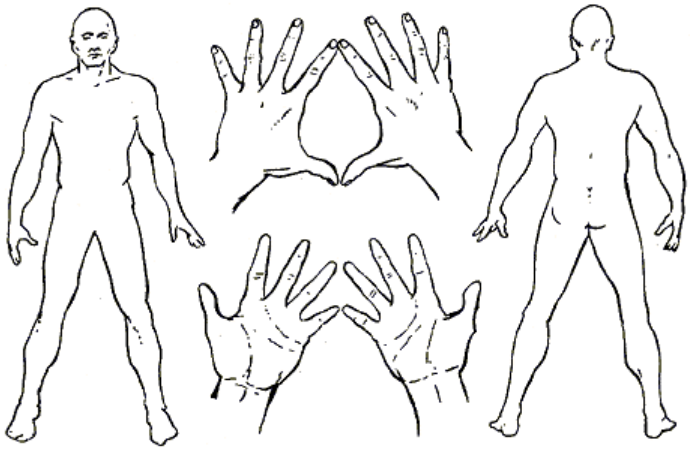
Do these symptoms interfere with: ❑Work ❑Sleep ❑Daily Activities ❑Other: _____

Have these symptoms occurred before? ❑Yes ❑No If yes, when: _____

Have you seen any other health care providers *for the same symptoms*? ❑Yes ❑ No

If yes: Provider's Name(s): _____

Type of treatment and results: _____



Use the symbols below to show us where your symptoms are on the pictures to the left.

Sharp pain:	/ / / / / /
Dull/aching pain:	✓✓✓✓✓✓
Stabbing pain:	△△△△△
Weakness:	# # # # # #
Numbness:	+ + + + + +
Burning:	X X X X X X
Pins and needles:	O O O O O O

MEDICATIONS PATIENT TAKES

❑Nerve Pills ❑Muscle Relaxers

❑Pain Killers (including Aspirin)

❑Blood Pressure Medicine

❑Anti-inflammatory Medicine

❑Stimulants ❑Blood Thinners

❑Tranquilizers ❑Insulin

❑_____ ❑_____

OTHER HEALTH CONCERNS

Do you have any other heath conditions that may cause complications with your treatment? (i.e. bruise easily, etc.)

Please Explain: _____

_____

_____

_____

In an effort to avoid a $20.00 cancellation fee, please notify your massage therapist of your cancellation within 24 hours of your appointment time.

By signing below, I understand the cancellation fee, and that the massage therapists, at Great Lakes Clinical Massage Therapy, do not diagnose patients.

_____/_____/_____

Print Name Signature Date