

**CONFIDENTIAL QUESTIONNAIRE FOR MASSAGE**

Date \_\_\_\_\_ How did you learn about us? \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Hm \_\_\_\_\_ Wk \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex:  F  M Marital Status:  S  M  D

Occupation/Activities \_\_\_\_\_

Injury Treatment?  Yes  No Date of Injury \_\_\_\_\_  Auto  Work  Other

Name of Referring Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Office Staff: New Referring Physician? \_\_\_\_\_ NPI# Added \_\_\_\_\_ Dr. Pkt Sent \_\_\_\_\_ Fax# \_\_\_\_\_

I have been given or offered and read the HIPAA information for Monroe Therapeutic Massage, P.S.

**Guardian or Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HEALTH INSURANCE**

Name of **Primary Insured** \_\_\_\_\_ **D. of B.** \_\_\_\_\_ **SS#** \_\_\_\_-\_\_\_\_-\_\_\_\_

Insurance Co. \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child

Insured Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

**Secondary Insurance (if applicable):**

Name of **Primary Insured** \_\_\_\_\_ **D. of B.** \_\_\_\_\_ **SS#** \_\_\_\_-\_\_\_\_-\_\_\_\_

Insurance Co. \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child

**AUTO INSURANCE**       **L&I / WORKER'S COMP**

Claim# \_\_\_\_\_ Claims Adjuster \_\_\_\_\_ Phone# \_\_\_\_\_

Attorney Name (if applicable) \_\_\_\_\_ Phone# \_\_\_\_\_

**PLEASE READ AND SIGN THE FOLLOWING:**

I acknowledge that the above information is complete and accurate to the best of my knowledge and I will notify Monroe Therapeutic Massage, P.S. and/or treating LMP of any changes in my physical condition, prior to treatment, or any changes in the information as presented on this form.

I agree to the release of information for medical and/or insurance purposes and authorize Monroe Therapeutic Massage, P.S. to obtain any information from my healthcare providers concerning my health.

I am aware that I am fully responsible for all health care bills for services rendered and that payment is not contingent on any settlement, judgment or insurance payment. An unpaid balance is due 30 days from statement/invoice date. A \$15.00 rebilling fee plus 1% interest or a minimum of \$1.00 will be charged until balance due is paid. Each bank returned check will be charged \$25.00. Additional court, attorney or collection agency fees may be charged if applicable.

**Missed appointment or cancellation with less than 24 hours notice will be charged \$35.00.**

**Guardian or Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HEALTH HISTORY**

Patient Name \_\_\_\_\_

**Have you ever experienced any of the following?** Please use 'C' for current, 'P' for past, 'S' for sometimes

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> HIV/AIDS             | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Sciatica          |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stiff Joints      |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Skin Allergies    |
| <input type="checkbox"/> Athletes Foot        | <input type="checkbox"/> Digestive Problems    | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Sprains/Strains   |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Disc Problems         | <input type="checkbox"/> Excess Stress       | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Back Pain            | <input type="checkbox"/> Diverticulitis        | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Swollen Feet/Legs |
| <input type="checkbox"/> Bone Fractures       | <input type="checkbox"/> Eczema                | <input type="checkbox"/> Muscle Spasms       | <input type="checkbox"/> Tendonitis        |
| <input type="checkbox"/> Bursitis             | <input type="checkbox"/> Epilepsy/Seizures     | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Tingling          |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Fibromyalgia          | <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Tumors            |
| <input type="checkbox"/> Chronic Fatigue      | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> Varicose Veins    |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Attack/Ailments | <input type="checkbox"/> Rashes              | <input type="checkbox"/> Whiplash          |
| <input type="checkbox"/> Colitis              | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Ringworm            | <input type="checkbox"/> Other _____       |

**For Women only:**

- |   |  |   |                              |
|---|--|---|------------------------------|
| <input type="checkbox"/> Pregnant           | <input type="checkbox"/> Trying to be Pregnant | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Amenorrhea            |   |                              |

**Accidents, Injuries or Surgeries:**

Less than 5 years ago \_\_\_\_\_

More than 5 years ago \_\_\_\_\_

Are you currently receiving medical or chiropractic care?  Yes  No

If yes, please explain \_\_\_\_\_

Are you taking any medications (prescription & over-the-counter)?  Yes  No

If yes, please explain \_\_\_\_\_

Do you wear hard contacts?  Yes  No

<b>Habits</b>	Heavy	Moderate	Light	None
Tobacco	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

What type of exercise? \_\_\_\_\_ How often? \_\_\_\_\_

Have you received massage before?  Yes  No

What did you especially like or dislike? \_\_\_\_\_

Why have you come for massage? \_\_\_\_\_

 **Guardian or Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**PATIENT PRESENT COMPLAINTS**

Name: \_\_\_\_\_

Please describe your current problem: \_\_\_\_\_

\_\_\_\_\_

How did the problem begin? \_\_\_\_\_

Date it began: \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Any range of motion restrictions? \_\_\_\_\_

What treatment(s) have you had for this condition? \_\_\_\_\_

How bad is your pain?	1	2	3	4	5	6	7	8	9	10
	No pain									Unbearable pain

How often are your symptoms present?  Constantly  Frequently  Occasionally  Intermittently

Describe your current pain/symptoms:  Shooting  Throbbing  Dull  Sharp/Stabbing  
 Burning  Numbness  Soreness  Tingling

Can you perform your daily **home** activities  w/out pain  w/pain - Explain \_\_\_\_\_

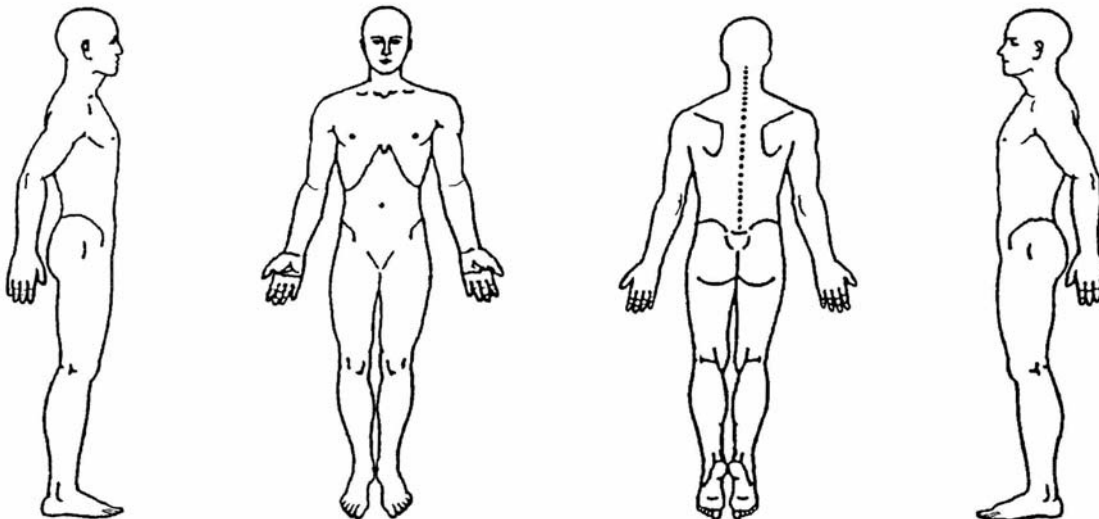
Can you perform your daily **work** activities  w/out pain  w/pain - Explain \_\_\_\_\_

How is the quality of your sleep? \_\_\_\_\_ Hours of sleep lost \_\_\_\_\_

What are your goals with massage therapy? \_\_\_\_\_

**Mark on the pictures where you have symptoms of pain, numbness or tingling**

"X" areas you do not want to be touched; genitals are never touched.



**Guardian or Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_