# What's New? (Massage)

**For the top portion (phone, address, etc.), please let us know if any of your info has changed.**
**If nothing has changed, you can leave the top portion blank.**

| Patient Name | | | | Today's Date |
|---|---|---|---|---|
| Street Address | | | Home Phone | Work Phone |
| City | State | Zip | Cell Phone | Best place to reach you: ❍ Home ❍ Work ❍ Cell |
| Marital Status ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widow | | Spouse Name | | # of Children |
| E-mail | | | | |
| Occupation | | | Employer | |
| Emergency Contact Name | | | Emergency Contact Phone # | |

## The Reason You're Here

What is your number-one problem or the one area of greatest pain? ______________________

When did this problem/pain start? ______________________ ❍Gradual ❍Sudden

What do you think caused this problem? ______________________

How are your symptoms changing? ❍Getting better ❍Not changing ❍Getting worse

Have you had similar conditions/symptoms in the past? ❍No ❍Yes. If yes, when? ______________________

Please list any other complaints that are currently bothering you: ______________________

Who else have you seen for this? ❍Nobody ______________________

What other care have you received for this? ❍None ______________________

## Your Previous Massage Therapy Experience

Date of last massage ______________________

If you've had massage in the past, *what did you enjoy most* about your previous experience(s)?

______________________

If you've had massage in the past, *is there anything that you would change* about your previous experience(s)?:

______________________

What type of atmosphere would you like during your massage visits?

❍ Quiet, relaxing & minimal conversation ❍ Lively with light conversation throughout ❍ No preference

Please rate your pressure preference ⇨ *I am Very Sensitive. Please Be Gentle.* 0 1 2 3 4 5 6 7 8 9 10 *I like a very deep massage*

❍ I don't know

Please take a moment to carefully read and answer the following questions. If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral from your chiropractor may be required prior to service being provided.

| | | | |
|---|---|---|---|
| Are you pregnant? | ❍Yes ❍No | Do you have any skin problems? | ❍Yes ❍No |
| Do you have varicose veins? | ❍Yes ❍No | Do you have cancer? | ❍Yes ❍No |
| Do you have a fever? | ❍Yes ❍No | Do you have any infectious diseases? | ❍Yes ❍No |
| Do you have high blood pressure? | ❍Yes ❍No | Do you have heart or circulatory problems? | ❍Yes ❍No |

Please add anything else you would like the massage therapist to know: ______________________

______________________

Patient Name______________________________________________________ Date____________

## Billing and Scheduling

- If you have any insurance information, please provide the staff with your insurance card and/or forms.
- There is a **$40 Scheduling Fee** for cancellations with less than **24 hours notice**, unless you are sick…
- **If you are sick, please reschedule** your massage appointment. You will *not* be charged a scheduling fee.

________ **Please initial** indicating that you have read and understand our Scheduling Fee policy.

## Client Bill of Rights for Massage

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

☐ **Please check** indicating that you have read this policy.

## Consent to Treatment of Minor

By my signature below, I hereby authorize the licensed massage therapist(s) at **Summit Family Chiropractic & Massage** to administer massage & bodywork techniques to my child or dependent as she deems necessary.

Signature of Parent or Guardian ____________________________________________________________

## Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorized this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such massage care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Client's Signature______________________________________________________________ Date ____________

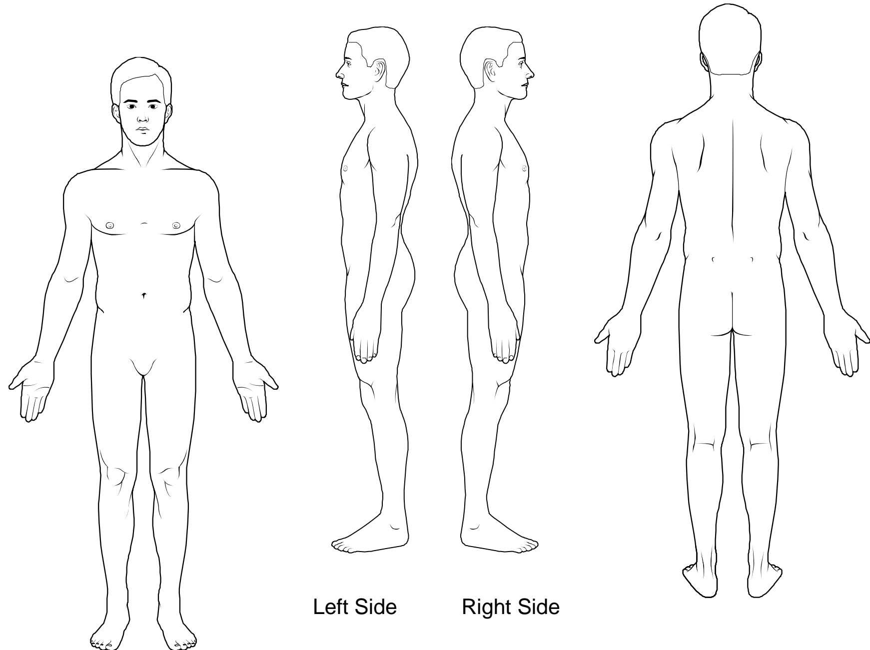
*(signature of parent if client is a minor)*

# Pain Drawing Quadruple Index

Patient Name_______________________________________________ Date____________

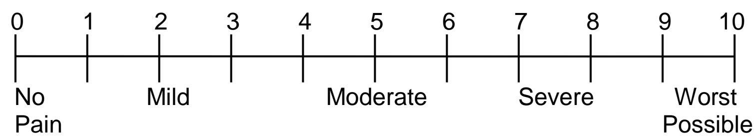
1. **Mark these drawings according to where you hurt** (If the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). **Please indicate which sensations you feel by referring to the key below.**

| KEY | |
|---|---|
| Stabbing | / / / / / / / / / / |
| Burning | X X X X X X |
| Pins & Needles | O O O O O |
| Aching | + + + + + + |
| Numbness | = = = = = = |

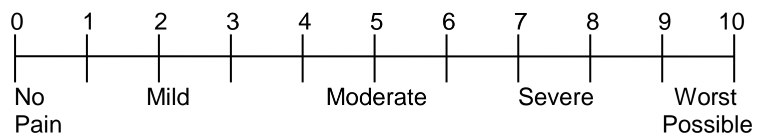



2. On the **FOUR** scales below, **please draw a vertical line** representing your pain or discomfort.

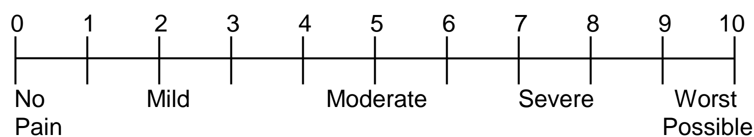
**A.** Rate the pain you have **RIGHT NOW:**



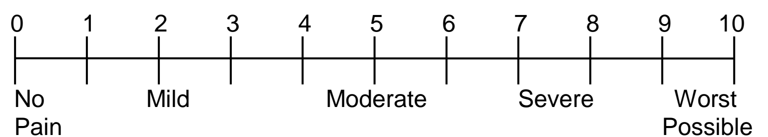

**B.** Rate your **AVERAGE** pain in the past week:




**C.** Rate your pain at its **BEST** in the past week:




**D.** Rate your **WORST** pain in the past week:



# Activities of Daily Living

Patient Name_______________________________________________ Date____________

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 circle the number which most closely describes your condition RIGHT NOW.

**Pain Intensity**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |

**Sleeping**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Perfect sleep | Mildly disturbed sleep | Moderately disturbed sleep | Greatly disturbed sleep | Totally disturbed sleep |

**Personal Care (washing, dressing, etc)**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain; no restrictions | Mild pain; no restrictions | Moderate pain; need to go slowly | Moderate pain; need some assistance | Severe pain; need 100% assistance |

**Travel (driving, etc.)**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain on long trips | Mild pain on long trips | Moderate pain on long trips | Moderate pain on short trips | Severe pain on long trips |

**Work**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do Usual work Plus unlimited Extra work | Can do usual work; no extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot work |

**Recreation**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do All Activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any activities |

**Frequency of Pain**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain | Occasional pain; 25% of the day | Intermittent pain; 50% of the day | Frequent pain; 75% of the day | Constant pain; 100% of the day |

**Lifting**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain with heavy weight | Increased pain with heavy weight | Increased pain with moderate weight | Increased pain with light weight | Increased pain with any weight |

**Walking**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain; any distance | Increased pain after 1 mile | Increased pain after ½ mile | Increased pain after ¼ mile | Increased pain with all walking |

**Standing**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after ½ hour | Increased pain with any standing |

Doctor's use only

FRI Score: