MEDICAL INTAKE

MASSAGE SOLUTIONS
of Bend

Date: ______________

Patient/Client Name: ______________________________

Date of Birth: ______________ Date of Injury: ______________

Mailing Address: ______________________________

City: ______________ State: ________ Zip: ________

Home Phone: ______________ Cell Phone: ______________

Email: ______________________________

For Insurance Use Only:

Primary Care Doctor: ______________ Do you have a prescription or referral: Y N

Primary Insurance: ______________ Referring Doctor: ______________

Policy#: ____________ Member ID: ____________ Group #: ____________

Claim #: ____________ Insurance Contact: ____________ Phone #: ____________

Fax #: ______________

Secondary Insurance Company: ______________________________

Emergency Contact: ______________ Relationship: ______________

Emergency Contact Phone: ______________________________

1. Please list any physical discomforts, injuries and/or concerns for your session today:

Pain at LOWEST: Rate your lowest pain level in past 24 hrs. 0 being No pain, 10 being worst pain imaginable: #________

Describe: ______________________________

____

Pain Currently: Rate your current pain level at this time. 0 being No pain, 10 being worst pain imaginable: #________

Describe: ______________________________

____

Pain at WORST: Rate your worst pain level in past 24 hrs. 0 being No pain, 10 being worst pain imaginable: #________

Describe: ______________________________

____

2. List one important activity you are unable or have difficulty performing as a result of your pain/symptoms *(stairs, reaching overhead, etc)*:

____

Rate your level of pain while trying to perform this task. 0 being No pain, 10 being worst pain imaginable: #________

3. What is your goal for therapy at this time? ______________________________

____

4. Are you presently receiving medical care, or taking medications? If yes, please describe:

____

5. Have you suffered any serious illness, injuries, trauma, been hospitalized or had surgery in the past 3 years?

____

6. Do you exercise regularly? If yes, describe types & frequency: ______________________________

____

7. Have you ever had professional bodywork; massage, chiropractic, or acupuncture? If yes, describe types & frequency: ______________________________

____

8. Please mark the location of your pain on the figure to the right.

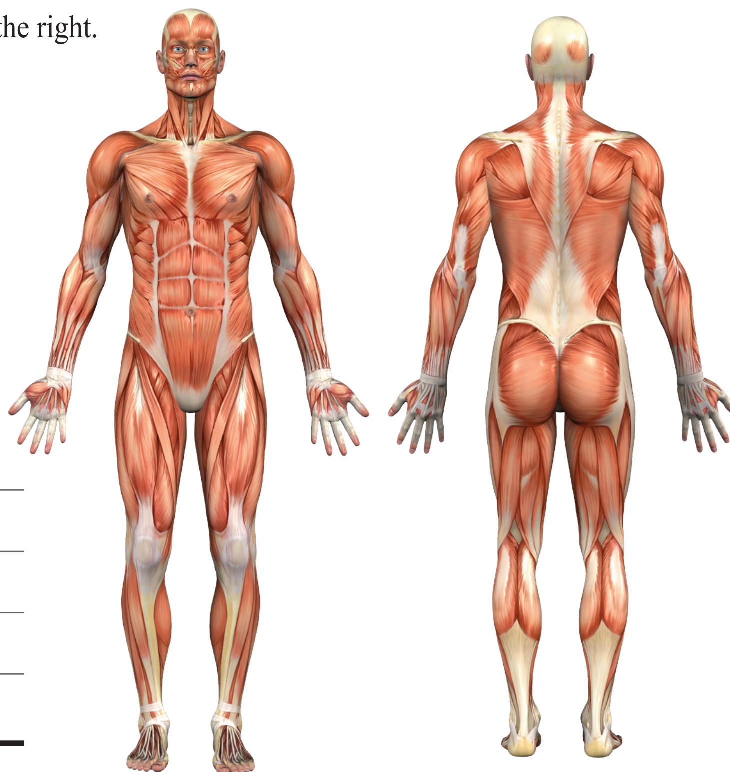
X sharp stabbing pain

0 dull achy pain

+ numb/tingling sensation

// throbbing

= = burning pain



9. Additional Comments or information:

____

____

____

____

____

I would like to be informed of the money saving Membership Program Y N

I would like to be informed of the Referral Reward Program Y N

Consent for Care:

It is my choice to receive therapeutic massage or bodywork, and hereby consent. I further understand that massage or bodywork is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature X ______________________________