

THERAPEUTIC MASSAGE AND NUTRITION CENTER
2420 N. WOODLAWN, BLDG 100, SUITE H, WICHITA, KS 67220
(316) 425-8003

PERSONAL INFORMATION

NAME: _____ DATE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ MOBILE PHONE: _____ WORK PHONE: _____
EMAIL: _____ DATE OF BIRTH: _____ AGE: _____ SEX: _____
EMERGENCY CONTACT: _____ EMERGENCY CONTACT PHONE: _____
MARITAL STATUS: _____ NAME OF SPOUSE (if married): _____ PHONE: _____
OCCUPATION: _____ REFERRED BY: _____
ARE YOU CURRENTLY UNDER DOCTOR CARE OR HAVE YOU SEEN A DOCTOR IN THE LAST 12 MONTHS? _____
IF YES, FOR WHAT REASON(S)? _____ PHYSICIAN(S): _____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT: _____
HOW DID IT HAPPEN? _____
WHEN DID YOUR CONDITION START? _____ IS THE CONDITION GETTING PROGRESSIVELY WORSE? _____
IS YOUR CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____
WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____
WHAT ACTIVITIES LESSEN YOUR CONDITION? _____
IS YOUR CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE? _____ OTHER? _____
OTHER DOCTOR(S) SEEN FOR THIS CONDITION: _____
TYPE OF TREATMENT(S) TRIED: _____
RESULTS: _____

HABITS

- | | |
|---|---|
| <input type="checkbox"/> Alcohol: Type _____ Amount _____ | <input type="checkbox"/> Sleep: Difficulty falling asleep _____ |
| <input type="checkbox"/> Caffeine: Coffee, cups daily _____ Other _____ | Continuity disturbances _____ |
| <input type="checkbox"/> Diet: Salt intake _____ Fat intake _____ | Early morning awakenings _____ |
| Other _____ | Daytime drowsiness _____ Other _____ |
| <input type="checkbox"/> Exercise: Routine _____ | <input type="checkbox"/> Smoking: Packs daily _____ How long? _____ |
| | Interested in stopping? _____ |

CURRENT MEDICATIONS: _____

SUPPLEMENTS: _____

(DRUG) ALLERGIES: _____

HOSPITALIZATION(S) (include date, reason): _____

MEDICAL HISTORY – please mark the conditions that apply to your personal health history.

- | | | |
|--|---|---|
| <input type="checkbox"/> Ringing in ears _____ | <input type="checkbox"/> High/low blood pressure _____ | <input type="checkbox"/> Change in bowel habits _____ |
| <input type="checkbox"/> Ear infections – frequent _____ | <input type="checkbox"/> Heart murmur _____ | <input type="checkbox"/> Diarrhea _____ |
| <input type="checkbox"/> Dizziness/fainting _____ | <input type="checkbox"/> Swollen ankles _____ | <input type="checkbox"/> Constipation _____ |
| <input type="checkbox"/> Failing vision _____ | <input type="checkbox"/> Leg pain – walking _____ | <input type="checkbox"/> Diverticulitis _____ |
| <input type="checkbox"/> Eye infections _____ | <input type="checkbox"/> Varicose veins/phlebitis _____ | <input type="checkbox"/> Crohn's/Coutis _____ |
| <input type="checkbox"/> Nose bleeds _____ | <input type="checkbox"/> Loss of appetite _____ | <input type="checkbox"/> Bloody or tarry stools _____ |
| <input type="checkbox"/> Sinus trouble _____ | <input type="checkbox"/> Difficulty swallowing _____ | <input type="checkbox"/> Hemorrhoids _____ |
| <input type="checkbox"/> Sore throat – frequent _____ | <input type="checkbox"/> Indigestion or heartburn _____ | <input type="checkbox"/> Hernia _____ |
| <input type="checkbox"/> Hayfever/Allergies _____ | <input type="checkbox"/> Persistent nausea/vomiting _____ | Urination: |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Peptic ulcers _____ | <input type="checkbox"/> Overnight > twice _____ |
| <input type="checkbox"/> Bronchitis/Chronic cough _____ | <input type="checkbox"/> Abdominal pain – chronic _____ | <input type="checkbox"/> Painful _____ |
| <input type="checkbox"/> Asthma/Wheezing _____ | <input type="checkbox"/> Gall bladder trouble _____ | <input type="checkbox"/> Loss of control _____ |
| <input type="checkbox"/> Chest pain _____ | <input type="checkbox"/> Jaundice/Hepatitis _____ | <input type="checkbox"/> Decrease in force/flow _____ |

- Urine infections – frequent _____
- Blood in urine _____
- Kidney stones _____
- Venereal disease _____
- Urethral discharge _____
- Chronic fatigue _____
- Weight loss – recent _____
- Anemia _____
- Bruise easily _____
- Cancer _____
- Diabetes _____
- Thyroid disease _____
- Convulsions/seizures _____
- Stroke _____
- Tremor/hands shaking _____
- Muscle weakness _____
- Numbness/tingling sensations _____
- Headaches – frequent _____
- Arthritis/rheumatism _____
- Osteoporosis _____
- Back pain – recurring _____
- Bone fractures/Joint injury _____
- Gout _____
- Foot pain _____
- Cold numb feet _____
- Rashes _____
- Hives _____
- Psoriasis _____
- Eczema _____
- Nervousness _____
- Depression _____
- Memory loss _____
- Moodiness – excessive _____
- Phobias _____
- Mental illness _____
- Lactose intolerant _____
- Prostate disease _____
- Sexual/menstrual dysfunction _____
- Frequent infections _____
- Diphtheria _____
- Tetanus _____
- Chicken pox _____
- Polio _____
- Mumps _____
- Measles _____
- Rubella _____
- Rheumatic fever _____
- Scarlet fever _____
- Tuberculosis _____
- Herpes _____
- Other _____

FEMALES (please complete):

- Pregnant _____
- Planning pregnancy _____
- Menstrual flow:
 - Regular _____
 - Irregular _____
- Pain/cramps _____
- Days of flow _____
- Length of cycle _____
- 1st day of last period _____
- Pain/bleeding during/after sex _____
- Number of Pregnancies _____
- Abortions _____
- Miscarriages _____
- Live births _____
- Birth control method _____
- B.C. pill (name) _____
- Flushing/menopause _____
- Date of last pap test _____
 - Normal _____
 - Abnormal _____
- Date of last mammogram _____
 - Normal _____
 - Abnormal _____

FAMILY HISTORY - please provide the following information about your family health history.

Relationship	Age, if living	Age at death	State of health or cause of death
Father			
Mother			
Brothers and Sisters			
Spouse			
Children			

Indicate any blood relatives who have had the following:

- Cancer _____
- Diabetes _____
- Gout _____ Blood disease _____
- Glaucoma _____ Epilepsy _____
- Tuberculosis _____ Heart disease _____
- High blood pressure _____
- Back problems _____ Rheum. Arthritis _____
- Other _____

AGREEMENTS

_____ (initial) I understand that all services are rendered on a cash, check or credit card basis. Unless other arrangements have been made, I agree to pay for each session at the time of the session. I also agree to the \$20 returned check charge in the event that my check is returned.

_____ (initial) Cancellation policy – I understand that any appointment not cancelled more than 12 hours prior to the scheduled time will be billed in full. There will be one “grace” given for one missed/late cancelled appointment.

_____ (initial) I understand that insurance is a contract between myself and my company, and in the case that insurance does not reimburse for massage therapy services rendered, I will be responsible for payment in full.

_____ (initial) The information I have provided is truthful and complete to the best of my knowledge. I assume responsibility for advising the therapist of any changes in my condition. Should I experience pain or discomfort during a massage, I will immediately inform the therapist.

_____ (initial) I understand that the Therapeutic Massage Center does not diagnose or prescribe and is not a substitute for physician diagnosis and treatment.

_____ (initial) I understand that the HIPPA policy of this office will not allow for any transfer of personal information without written/signed consent of the client.

Client Signature: _____ Date: _____

(For Minor) Parent/Guardian Signature: _____ Date: _____