Myo Therapeutic Massage

1836 Hamilton Avenue
San Jose, CA 95125

Date:_____

Patient's Name_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work_____ Cell_____

Birthdate _____

Nearest Relative _____ Phone _____

Emergency Contact_____ Phone_____

How did you hear about us? Friend ___ Internet ___ Yellow Pages ___

Email_____

Other_____

PLEASE READ: (Fill in ONLY if you have a claim for workers comp or personal injury)

Do you have medical insurance coverage that covers massage therapy? Yes No

Insurance Carrier_____

Group/ Policy Number_____

Insurance Phone Number_____

I understand that I am fully responsible for payment. By signing the following, I agree to make all payments due to Dimensions In Health and or practitioners. I understand that if my insurance does not pay for services rendered, I am responsible for payment.

I understand that I must give a 24-hour cancellation notice. If I cannot make my scheduled appointment date, a charge of up to $75 will be applied for all missed appointments. This applies to all series programs that Dimensions In Health offers to its clients.

_____

Patient's/ Guardian's Signature Date

Myo Therapeutic Massage

Purpose of this appointment:

Remarks and Additional Information:

	Severe	Mild	No	CARDIO VASCULAR	Yes	No		Yes	No
Back Pain				Hardening of Arteries			Are you taking Medication		
Backache				High Blood Pressure					
Boils				Low Blood Pressure			For Your Heart		
Bruises				Pain over Heart			Blood Thinners		
Chest Pain				Paralytic Stroke			Others		
Dizziness				Poor Circulation			Type:		
Dryness				Previous Stroke			Prescription:		
Faulty Posture				Rapid Beating Heart					
Foot Problems				Slow Beating Heart			Are you under care of:		
Headache				Swelling of Ankles			Physician		
Hernia				Blood Clots			Chiropractor		
Hives or Allergies							Therapist		
Irritability				FOR WOMEN ONLY					
Itching							Do you have Allergies To		
Neck Pain				Premenstrual Tension			Fragrances		
Nervousness				Congested Breast			Flowers		
Pain in Shoulders				Menstrual Cramps			Oils		
Painful Tailbone				Menstrual Backache					
Sensitive Skin				Are you Pregnant?			Are You Wearing		
Skin Eruptions							Contact Lenses		
Sleeping Problems				HABITS			Hearing Aids		
Spinal Curvature							False Eye		
Stiff Neck				Sugar Cravings			Do you bruise easily		
Swollen Joints				Coffee			Do you take Vitamins		
Tension				Tea			Dietary Supplements		
Tremors				Tobacco			Herbs		
Varicose Veins				Alcohol			Others		
				Soft Drinks					

Hospitalized in the past 6 months?

What changes do you feel could benefit you in reaching your health goals?

Change in Weight (Loss _____ pounds/Gain of ____.____)

Change in Diet	**Change in exercise program**
Ability to handle Stress	**Other**

What are your interests in Massage Therapy

PLEASE MARK YOUR AREAS OF PAIN