ADVANCED
MUSCLE THERAPY

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Name: _____,_____,_____ **Date of Birth:** _____
FIRST **MI** **LAST**

Address: _____ **Zip Code:** _____

Phone Number:_____ **EMAIL:** _____

Emergency Contact:_____ **Relationship:**_____ **Phone:**_____

How did you hear about Advanced Muscle Therapy? _____

MEDICAL HISTORY – Do you have or have you had:

Anemia	☐ Yes	☐ No
Arthritis:_____	☐ Yes	☐ No
Breathing Problems:_____	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chronic Fatigue	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Digestive disorder:_____	☐ Yes	☐ No
Dizziness/vertigo	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Gout:_____	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Heart Problems:_____	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Skin problems:_____	☐ Yes	☐ No
Stroke	☐ Yes	☐ No

Other: _____

Primary reason for today's visit:_____

_____

Pain Level (1 = No Pain, 10 = ER-worthy): _____

Chronic Pain Areas (Circle all that apply)
Neck | Upper Back | Shoulder | Arm | Elbow | Wrist/Hand
Mid-Back | Lower Back | Hip | Leg | Knee | Ankle/Feet

Accidents, Injuries, Surgeries, Hospitalizations
Please list approximate dates and treatments received:

_____

_____

_____

Current Care
Are you currently under a physician's care? ☐ Yes ☐ No
If yes, for what condition(s)? :_____

_____

Current Medications/Supplements:_____

_____

_____

***Female Clients*:** Are you pregnant? ☐ Yes ☐ No

I certify that the above information is accurate. I understand that massage therapy is not a substitute for medical care and does not diagnose or prescribe. I agree to notify my therapist of any changes in my health. My signature indicates consent for treatment and ability to participate in desired programs.

Cancellation Policy: 24-hour notice required. Late cancellations or missed appointments are subject to the full session fee.

Signature: _____ **Date:**_____

********* OFFICE USE ONLY ********** OFFICE USE ONLY ********** OFFICE USE ONLY **********

Continuation of Treatment Record/Additional Information:_____

_____

_____

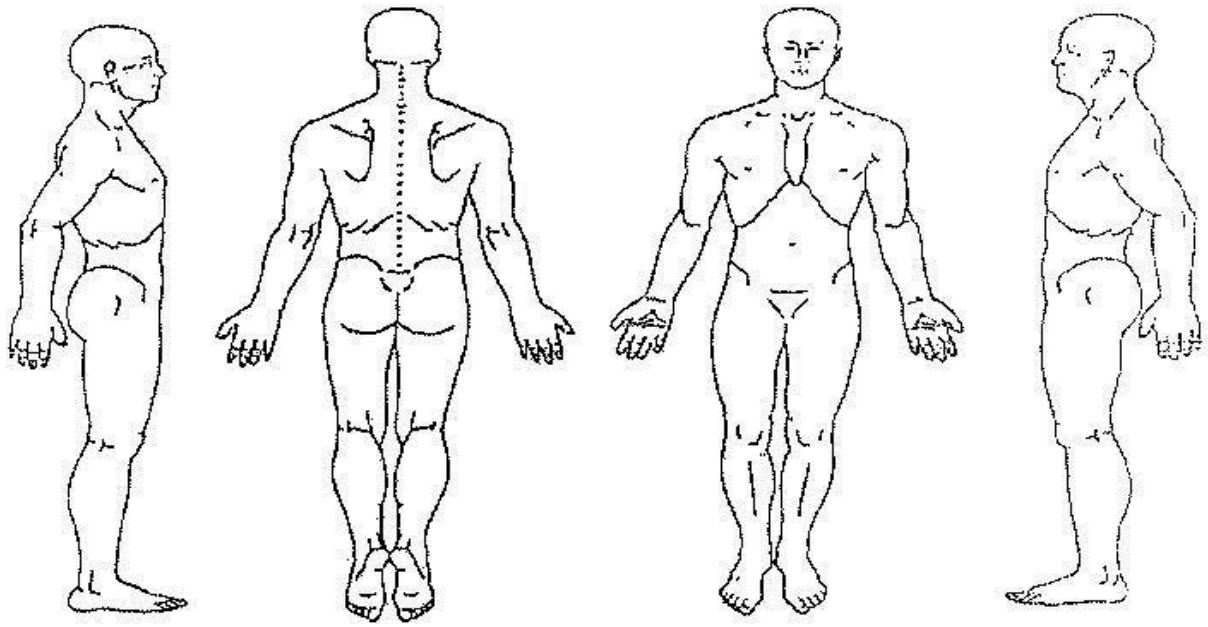
_____

_____

Please initial to validate information: _____

**********REMAINDER OF DOCUMENT FOR PROVIDER USE ONLY**********

Treatment date:_____ DOI:_____



Subjective Info (client reported) _____

_____

_____

Objective Info (assessment) _____

_____

_____

Action (today's treatment)_____

_____

_____

Plan (Clinical & At-home Treatment) _____

_____