Great Lakes Clinical Massage Therapy

Patient Health Record

Please fill out our *confidential* patient health record completely and accurately.

Clinical Massage Therapy is a soft tissue therapy that utilizes deep tissue massage, manual joint mobilization, hot/cold therapy, and therapeutic exercise procedures to reduce, pain, spasm, and inflammation.
If you have any questions, please don't hesitate to ask.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being possible.

ABOUT THE PATIENT

Name: ____

Address: ____

City: __________________State: _____Zip: _________

Phone: Home: (___)___________ Cell : (___)___________

Email address: ___________________________________

Birthdate: ____________ Age: ______ Gender: ❑M ❑ F

Type of Work: _______________________________

HOW DID YOU HEAR ABOUT THE OFFICE?

❑Drive By ❑Google ❑Facebook

❑Website ❑Flyer ❑Phone Book

❑Referral: _______________________________

❑Other: __________________________________

Do you have family or friends who are treated here?

❑Yes ❑No

FOR OFFICE USE ONLY

First Appointment Date: ___________________

Therapist: _______________________________

EXPERIENCE WITH TREATMENT

Have you had a massage before? ❑Yes ❑No

Approximate date of last visit: _________________________

Type of Treatment: ❑Clinical ❑Relaxation ❑Other

What were your results? _______________________________

____

IN AN EMERGENCY, CONTACT:

Name: ____________________________

Relationship: _______________________

Cell Phone: _(_____)_________________

Other Phone: _(_____)________________

REASON FOR THIS VISIT

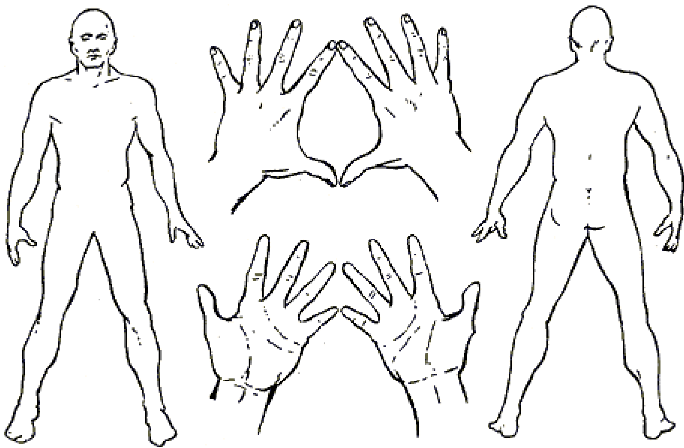
Tell us about your symptom(s): ____

Is the purpose of this visit related to: □Job ❑Sports Injury ❑Auto Accident ❑Home Injury
❑Chronic Discomfort ❑Fall ❑Other, Please explain: ______________________________

Do you have any allergies to products: ____

Have you seen any other health care providers *for the same symptoms*? ❑Yes ❑ No
If yes: Provider's Name(s): ____

Type of treatment and results: ____



Use the symbols below to show us where your symptoms are on the pictures to the left.

Sharp pain:	/ / / / / / /
Dull/aching pain:	✓✓✓✓✓✓
Stabbing pain:	△△△△△
Weakness:	# # # # # #
Numbness:	+ + + + + +
Burning:	X X X X X X
Pins and needles:	O O O O O O

MEDICATIONS PATIENT TAKES

❑Nerve Pills ❑Muscle Relaxers
❑Pain Killers (including Aspirin)
❑Blood Pressure Medicine
❑Anti-inflammatory Medicine
❑Stimulants ❑Blood Thinners
❑Tranquilizers ❑Insulin
❑_______________ ❑_______________

OTHER HEALTH CONCERNS

Do you have any other heath conditions that may cause complications with your treatment? (i.e. bruise, surgeries, etc.)

Please Explain: ______________________________
____
____
____

In an effort to avoid a $25.00 cancellation fee, please notify your massage therapist of your cancellation within 24 hours of your appointment time.

By signing below, I understand the cancellation fee, and that the massage therapists, at Great Lakes Clinical Massage Therapy, do not diagnose patients.

______________________/______________________/______________
Print Name Signature Date