New Patient Intake

Patient Name **Date**

General Information

Address City State

Home Phone Occupation Zip

Work Phone SS# Date of Birth

Mobile Phone E-mail

Emergency Contact Relationship Phone

Family Physician Phone

☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

If you were referred to us, who referred you?

☐ Please check the box if you would like to receive special offers and a birthday gift from True Skin Holistic Wellness.

Insurance Information

Which type of insurance do you have? ☐ Private Health Insurance ☐ Auto Accident ☐ Labor & Industries

If you wish for our office to bill your private insurance please provide a copy of your insurance card. Once your insurance coverage has been verified we will be glad to accept payment directly from the insurance company. By signing below you acknowledge that there is no guarantee of payment from your insurance company and all charges are your responsibility.

Health History

Current	Past	**Head**
☐	☐	Headache
☐	☐	Concussion
☐	☐	Whiplash

Current	Past	**Muscles & Joints**
☐	☐	Rheumatoid Arthritis
☐	☐	Osteoarthritis
☐	☐	Scoliosis
☐	☐	Disk Degeneration
☐	☐	Herniated Disk
☐	☐	Ruptured Disk
☐	☐	Lupus
☐	☐	Tendonitis
☐	☐	Bursitis
☐	☐	TMJ, Jaw Pain
☐	☐	Fibromyalgia

Current	Past	**Endocrine System**
☐	☐	Thyroid Dysfunction
☐	☐	Diabetes
☐	☐	Bladder/Kidney Dysfunction

Current	Past	**Skin Conditions**
☐	☐	Rashes
☐	☐	Warts
☐	☐	Athletes Foot

Current	Past	**Nervous Systems**
☐	☐	Dizziness
☐	☐	Ringing in Ears
☐	☐	Loss of Memory
☐	☐	Sciatica

Current	Past	**Cancer/Tumors**
☐	☐	Benign
☐	☐	Malignant
☐	☐	Other

Current	Past	**Digestive System**
☐	☐	Endometriosis
☐	☐	Irritable Bowels
☐	☐	Crohn's Disease
☐	☐	Other

Current	Past	**Allergies**
☐	☐	Lotions
☐	☐	Detergents
☐	☐	Other

Current	Past	**Cardiovascular/Respiratory**
☐	☐	Heart Disease
☐	☐	Blood Clots
☐	☐	Stroke
☐	☐	Heart Mummer
☐	☐	Chest Pain
☐	☐	Lymphedema
☐	☐	Poor Circulation
☐	☐	Swollen Ankles
☐	☐	Varicose Veins
☐	☐	High/Low Blood Pressure
☐	☐	Other

Current	Past	**Reproductive System**
☐	☐	Pregnancy (# of weeks: _____)
☐	☐	Fibrotic Cysts
☐	☐	Abdominal Pain
☐	☐	Other

Health Report

Have you recieved massage therapy before? ☐ No ☐ Yes – How often?

Do you currently have any infectious/contagious diseases? ☐ No ☐ Yes – Please explain:

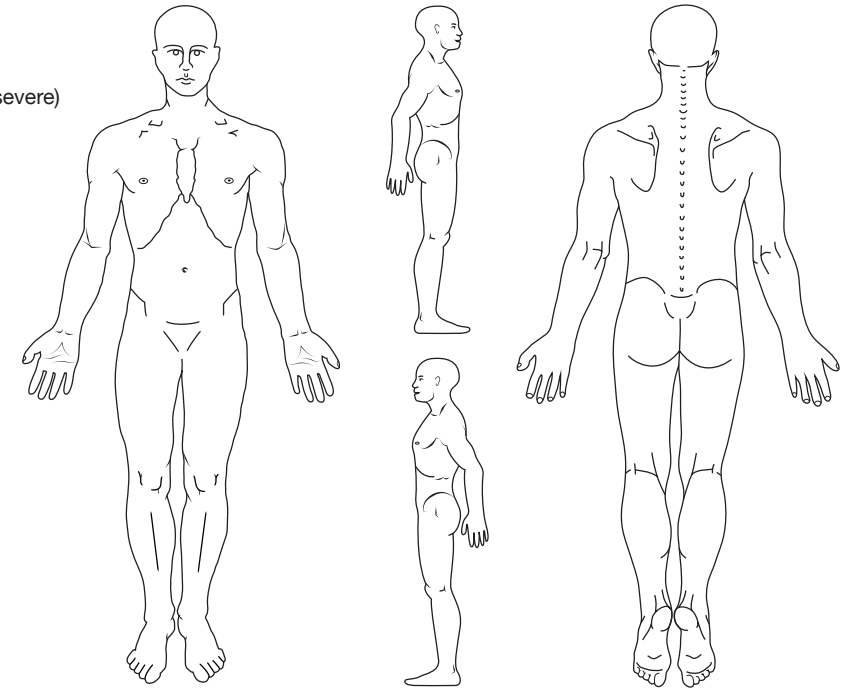
List all skin conditions:

List surgeries and broken bones:

List all current medications:

Instructions:
1) Circle the areas that are bothering you today
2) Write the letter in the circle to describe what you are feeling
3) Rate the feeling on a scale from 1-10 (1: mild, 5: moderate, 10: severe)

P: pain
T: tension/stiffness
N: numbness/tingling
A: ache
B: burning
HA: headache
O: other (explain)



Consent for Care

- It is my choice to receive manual therapy, and I give my consent to receive treatment.
- I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.
- I understand manual therapy is not a substitute for medical examination or diagnosis.
- I understand that massage practitioners do not diagnose illness or disease, nor prescribe medical treatment, pharmaceuticals, or perform manipulations.
- I understand that my manual therapist reserves the right to stop the massage at any time if deemed necessary.
- I give my permission for my therapist to speak with my referring health care provider regarding my care.

I confirm that the above information is correct to the best of my knowledge

Signature _____ Date _____

Signature of Parent or Guardian if patient is a minor