

RELIEF ZONE

540 CHAMA NE SUITE 10, ALBUQUERQUE, NM 87000, 505-888-ZONE(9663)

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Patient Information: First Name: _____ M.I. _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone(h): _____ (w) _____ Cell# _____

Employer: _____ Occupation: _____

Emergency contact: _____ Phone: _____ Relationship: _____

D.O.B.: _____ SS#: _____ Relation to Insured: _____

Is this a work comp injury? ___yes ___no. **Auto accident?** ___yes ___no. **Date of Injury:** _____

Type of Injury: _____

Employer: _____ Occupation: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Is this a minor child? ___yes ___no. Parent or Legal Guardian _____

Referred by: _____ E-mail: _____

What symptoms are you having? _____

What is your chief complaint? _____

What do you hope to accomplish today or from this treatment in our office? _____

Describe any surgeries, hospitalizations, accidents or injuries, and/or broken bones you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

What kind of care did you receive for your accident(s) or injury(s)? _____

Please list any medications (vitamins, herbs or pharmaceuticals) taken now or at regular intervals:

Medication/Herb	Reason for Taking	Dosage	Frequency (how often you take it)	Does it help? Are there side effects?

Are you receiving any other type of medical treatment? _____ Please explain: _____

Is there anything else we should know? _____

Describe what activities cause this pain and/or make it worse: _____

Referring Dr. _____ **Ref. Dr. Phone #:** _____

Ref Dr. Address: _____

Is this your Primary Care Provider? _____ If No, please provide name: _____

Attorney Name: _____ **Address:** _____

Phone: _____ **Case Number:** _____

Insurance Company: _____

Ins. Co. Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____

Insurance Claim Number: _____ **Policy Number:** _____ **Group or I.D.#:** _____

Subscriber's First Name: _____ **M.I.:** _____ **Last Name:** _____

Subscriber's S.S.#: _____ **D.O.B.:** _____

Name of Employer: _____

Actively Enrolled yes no **Waiting Period** yes no

Benefit Limit: _____ **Massage Benefits Grouped with** _____

Deductible: _____ **has been met?** yes no **Co-pay Amount:** _____ **or % Insurance Pays** _____

■ *We invite you to discuss with us any questions regarding our services.* The best health services are based upon open communication and mutual understanding between provider and patient.

■ *Our policy requires payment in full for all services rendered at the time of visit,* unless other arrangements have been made with the business manager. If account is not paid within 35 days of the date of service your credit card will be billed monthly for the payment co-payment amount stated on your insurance card. If not paid within 90 days, and no financial arrangements have been made, you will be responsible for legal fees, collections agency fees, and any other expenses incurred in collecting your account.

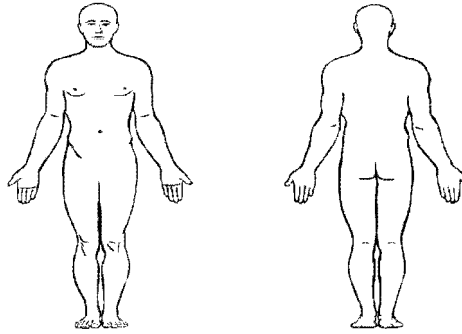
■ *I authorize the staff to perform any necessary services needed during diagnosis and treatment.* I also authorize the provider and or managed care organization, to release any information required to process **insurance claims**.

■ *I understand the above information and guarantee this form was completed correctly* to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

■ *I understand that it is my responsibility this office and other organizations involved in my care of any changes* to my insurance policy, address, phone number(s), or care coverage.

Signature: _____ **Date:** _____

Please indicate where you experience pain on the drawing below



Are you currently experiencing any of the following conditions?

Flu or Cold Inflammation Fever Infection Contagious Disease

Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

MUSCULOSKELETAL

- Fibromyalgia
- Spasms/Cramps
- Sprains/Strains
- Osteoporosis
- Postural Deviations
- Gout
- Osteoarthritis/Rheumatoid Arthritis
- TMJ
- Cysts
- Bursitis
- Plantar Fasciitis
- Tendonitis
- Torticollis
- Whiplash Syndrome
- Carpal Tunnel Syndrome
- Sciatica
- Thoracic Outlet Syndrome
- Headache
- Leg Pain
- Arm Pain/Shoulder Pain
- Low Back Pain
- Mid Back Pain
- Hip Pain
- Other _____

RESPIRATORY

- Pneumonia
- Sinusitis
- Asthma
- Trouble Breathing
- Dizziness
- Other _____
- Do you Smoke? If so,
How much? _____

CIRCULATORY

- Anemia
- Hemophilia
- Hypertension
- Low Blood Pressure
- Raynaud's Disease
- Varicose Veins
- Heart Condition
- Blood Clots/Phlebitis
- Diabetes
- Other _____

DIGESTIVE

- Ulcers
- Irritable Bowel Syndrome
- Colitis
- Gallstones
- Hepatitis
- Crohn's Disease
- Diarrhea
- Gas/Bloating
- Indigestion
- Other _____

SKIN

- Fungal Infections
- Acne
- Impetigo
- Dermatitis/Eczema
- Psoriasis
- Open Wound or Sore
- Rashes
- Warts/Moles
- Athletes Foot
- Other _____

NERVOUS SYSTEM

- ALS
- Multiple Sclerosis
- Parkinson's Disease
- Bell's Palsy
- Neuritis
- Spinal Cord Injury
- Stroke
- Trigeminal Neuralgia
- Seizure Disorders
- Numbness/Tingling/Twitching
- Other _____

OTHER

- Insomnia
- Anxiety/Panic Attacks
- PMS
- Grief Process
- Cancer
- Substance Abuse
- Pregnancy
- Chronic Fatigue
- HIV/AIDS
- Lupus
- Kidney Disease
- Bladder Infection
- Postoperative Situation
- Edema
- Other _____
- Do you take drugs? If so,
What kind? _____
How often? _____

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health.

Signature: _____ Date: _____