Patient Confidential Health Profile
Fulcher Therapeutic Massage LLC

Please complete both sides

Patients name: _____ DOB: _____ Age:_____ M:___ F:___
Home phone: _____ Cell phone: _____ Text? Y:___ N:___
Address: _____ City: _____ State: ____ Zip: _____
Email: _____ Email: Y:___ N:___
Employer: _____ Occupation: _____ Work Ph:_____
Emergency contact: _____ Phone: _____
Referred By:_____

Medical care

Previously received professional Massage Therapy or Bodywork Treatment? Y: ___ N: ___
Primary healthcare provider: _____ Phone: _____
List all prescribed/over-the-counter medications and conditions treated:
Medications: _____ Reasons: _____
_____ _____
_____ _____
_____ _____
_____ _____

Complete below for prescribed / medically necessary treatment only

Referring physician: _____ Phone: _____ Fax: _____
Is accident related to: Auto: ___ Work: ___ other: _____ Date of accident or onset: _____
Describe accident: _____
_____
_____

Insurance information

Name of insured: _____ SS#: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance Company: _____ Phone: _____
Contract #: _____ Group #: _____
Adjuster: _____ Phone: _____ Claim #: _____

Attorney (if applicable)

Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.
In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due.
I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.
I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.
Appointments not canceled 12 hours in advance are subject to a $25 fee.

Patient signature: _____ Date: _____

Parent or Guardian signature of minor: _____

Please continue to the other side. Thank you.

Personal Health History

Please check the conditions you are experiencing now or have in the past

O allergies	O chronic cough	O rash	O arthritis
O convulsions	O shortness of breathe	O sensitive skin	O epilepsy
O dizziness	O asthma	O eczema	O hemophilia
O fatigue	O emphysema	O bruise easily	O diabetes
O headaches	O heart disease/attack	O varicose veins	O internal pins/wires
O fibromyalgia	O high/low blood pressure	O psoriasis	O artificial joints
O TMJ	O stroke/CVA	O sinus	O degenerated discs
O ear problems	O vertigo	O cancer	

O allergies to oils/lotions/aromatherapy

Females: O pregnant; due date: _____ Males: O prostate cancer

Communicable diseases: O TB O hepatitis O HIV O shingles

Is your injury or condition interfering with: O work O sleep O sports O daily routine
If yes, please describe: _____
_____

Muscle Pain and Tension: Please rate pain on scale of 1-10, 10 being worst

Neck:	Shoulders:	Arm:	Leg:	Back:
Right _____	right _____	right _____	right _____	upper _____
Left _____	left _____	left _____	left _____	mid _____
				Low _____

Surgical Procedures and dates:
_____
_____

Please shade areas of pain: