Patient Update

Name: _____ Date: _____

After your last visit, how long were your symptoms improved? _____

At the time of this visit are you feeling ❑ better ❑ worse ❑ same compared to how you felt at your last visit?

Please describe _____

Symptoms improve with ❑ Rest ❑ Activity ❑ Hot/Cold Packs ❑ Therapeutic Massage ❑ Medication

Symptoms worsened by ❑ Work ❑ Standing ❑ Sitting ❑ Lying down ❑ Activity ❑ Exercise ❑ Other _____

Since your last visit, have you experienced any of the following?

❑ Headaches: Frequency_____ Duration_____ Intensity _____

❑ Neck pain or stiffness: _____

❑ Shoulder pain or stiffness: _____

❑ Back pain or stiffness: _____

❑ Hip/Pelvic pain or stiffness: _____

❑ Arm or Leg pain or stiffness: _____

❑ Sleep difficulty: _____

On a scale of 1 to 10, mark the level of pain you are experiencing today on the figures to the right.

Please mark any areas of numbness, dysfunction, discomfort, tingling, pins and needles, burning, aching, stabbing pain, spasm, stiffness, or preferred area(s) of focus and describe below:

_____

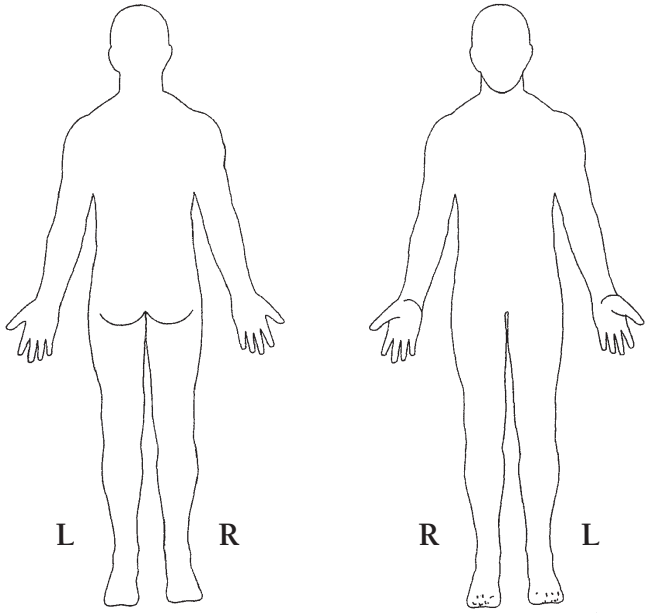
_____

_____

_____

_____

Patient (or Guardian's) Signature



How to rate your symptoms on a pain scale of 1 to 10

10 Your pain is **intense, constant**, greatly restricts your activities, and it is impossible to go more than **5** minutes without awareness of the pain.

9 Your pain is **intense, constant**, greatly restricts your activities, but you can forget about the pain for up to **15** minutes at a time.

8 The pain is **significant**, moderately **intense** at times, but **not constant**. Most activities are affected, and you think about it once or twice an hour.

7 The pain is **significant** at times, but **never intense** and **not constant**. Most activities are affected, and you think about it once or twice an hour.

6 The pain is **moderate**, yet too frequent to ignore. **Some activities are affected**. Hours can go by without being aware of the pain.

5 The pain is **moderate**, yet too frequent to ignore. **Almost no activities are affected**. Hours can go by without being aware of the pain.

4 The pain is little more than a **nuisance**, and you go through your whole day **frequently aware**, but not really affected by it.

3 The pain is little more than a **nuisance**, your awareness of the pain may be **absent for a whole day** at a time, and you are never affected by it.

2 At it's worst, the pain is best described as **uncomfortable**. Days can go by without being aware of it.

1 At it's worst, the pain is best described as **uncomfortable**. Your symptoms **do not recur more frequently than once a week.**

Medical History

yes *no*

❑ ❑ Are you wearing medical devices? ❑ Contacts ❑ Dentures ❑ Hearing Aid ❑ Other_____

❑ ❑ Do you suffer from any of the following?

❑ Skin disorders: ❑ Rash ❑ Yeast ❑ Fungus ❑ Psoriasis ❑ Infection ❑ Other_____

❑ Allergies: ❑ Latex ❑ Peppers ❑ Oils ❑ Nuts ❑ Skin care ingredients ❑ Other _____

❑ ❑ Are you under the care of a physician for any reason? Please explain _____

❑ ❑ What medications are you taking and when was your last dose? _____

❑ ❑ Any recent/current illnesses? ❑ Infectious ❑ Viral ❑ Bacterial ❑ Other _____

❑ ❑ Have you ever been diagnosed with any of the following conditions?

❑ Arthritis. Type and location(s)_____

❑ High blood pressure ❑ Low blood pressure ❑ Aneurism ❑ DVT ❑ Other _____

❑ Heart Disease

❑ Diabetes: ❑ Type I ❑ Type II (Adult Onset) ❑ Other _____

❑ Cancer. Type and location(s) _____

❑ Spinal condition: ❑ Scoliosis ❑ Osteoporosis ❑ Other _____

❑ Asthma ❑ Other medical condition(s) _____

Date(s) of diagnosis of any of the above conditions _____

❑ ❑ Have you ever had surgery?

Affected area of the body _____ Date/Year(s) _____

❑ ❑ *Menstrual cycle issues:* ❑ *Pain/Cramping* ❑ *Irregularity* ❑ *Other* _____

❑ ❑ *Are you now pregnant? What trimester?* _____ *Any complications?* _____

❑ ❑ Do you have any needs that require special attention? _____

❑ ❑ Do you have any questions before we get started? _____

General Understanding

I understand that Clinical Massage Therapy and other related health care services from this office are not in any way to be used instead of or in place of consulting a Physician for diagnosis and treatment of any physical symptoms, but to be used in conjunction with, or on the advice, referral, or prescription of, my Physician(s).

_____ Please initial.

I understand that my scheduled appointments are reserved exclusively for me. I agree to call my therapist as soon as I know I cannot keep an appointment. All missed appointments, and cancellations made after 5pm the business day preceding any scheduled appointment, will be billed at $25.00 per half hour for the time reserved. I agree to be responsible for these charges, and payment will be made before the time of my next visit. If I miss two appointments without notice, my treatment will be terminated and I will pay full price for my missed appointments. I understand that this policy is in place to assist *Superior Massage LLC* and my therapist in providing the best possible care to me and all others who benefit from these services. _____ Please initial.

By my signature, I verify that all information provided is true and correct to the best of my knowledge. I promise to keep *Superior Massage LLC* updated on any changes in my health and residence. I understand that in the therapy session(s) my comfort level will always come first and that I, or the therapist, may request the treatment to stop or change for any reason. I agree to payment at the time of service by cash or check. I agree to pay a $25 fee for any returned NSF checks.

Patient (or Guardian's) Signature _____ Date _____

Superior Massage LLC · 358 Superior St SE, Suite 200 · Salem, OR 97302 · fax 503/362-5350 · aleta@superiormassagellc.com