Center for Clinical Massage located at Competitive Edge Chiropractic
22672 Lambert St. – suite 601, Lake Forest, CA. 92630
949-510-4946

Initial Appointment Date_____

Last Name_____ First Name_____

Address_____

City_____ State_____ Zip_____

Home Phone (____)_____ Work (____)_____ Cell (____)_____

E-mail (office use only)_____ Fax (____)_____

Occupation_____

Date of Birth _____ Height_____ Weight_____ Sex _____

Marital Status:

Insurance Provider_____

Spouses Name (if applicable) _____

Spouses Occupation _____

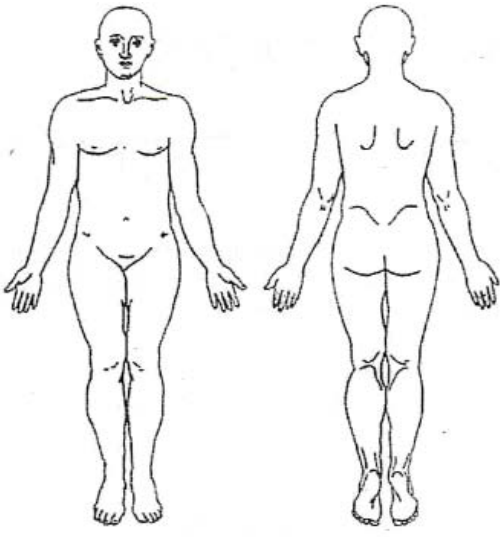
How did you find out about us? _____

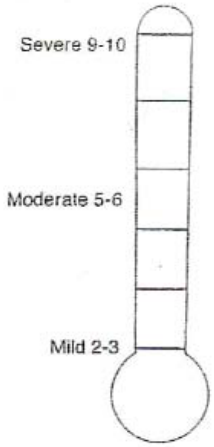
What is your reason for coming to see us today? _____

_____

Where exactly is the problem? _____

Mark the figure below to specify your pain areas. (follow directions below or print form out)
(go to top and click on **tools**, **comment & markup**, click on **show comment & markup tool bar**)
Rate the recent level of pain by shading in the thermometer below.
Has it been getting Better or Worse?





Describe how it feels: aching, cramping, dull, sore, deep, sharp, shooting, stabbing, sting, tingling, burning, numbness, radiating – if so where?_____

How did it start the first time _____

If this is not the first time, how did it happen this time? _____

Was the onset (Sudden or Gradual)?_____

What movements were you doing at the time of injury? _____

How often does it bother you? (Constant all the time, everyday, ___x per week ___x per month)

How long does it last once it is there? (Always there, ____ hours/minutes_____, no pattern____)

What specifically makes it worse? (Certain movements/activities, stress, time of day, no pattern)

_____

What makes it feel better? (Certain movements/activities, heat/ice, time of day, therapies, nothing)

_____

Do you have a diagnosis from a Doctor?

If, yes list it and name of the doctor.

Diagnosis_____ Doctor_____

Other therapies/remedies tried and results:

_____

Have you ever had any surgeries and were they beneficial at the time? _____

_____

List any other health problems for which you are being treated: _____

_____

Current Medications: (including asprin, ibuprofen, etc.) . _____

_____

Check the list below and check any condition that applies to you.

Muscular and Skeletal

____ tendonitis
____ bursitis
____ broken / fractured bones
____ arthritis
____ sprains / strains
____ low back, hip, leg pain
____ neck, shoulder, arm pain
____ headaches / head injuries
____ spasms / cramps
____ jaw pain / TMJ

Autoimmune System

____ fibromyalgia
____ lupus
____ other _____

Circulatory System

____ heart condition
____ varicose veins
____ blood clots
____ high blood pressure
____ low blood pressure
____ lymph edema
____ breathing difficulties
____ sinus problems
____ other _____

Skin

____ allergies
____ rashes
____ athletes' foot
____ warts
____ other _____

Digestive System

____ constipation
____ gas / bloating
____ diverticulitis
____ irritable bowel syndrome
____ other _____

Nervous System

____ herpes / shingles
____ numbness / tingling
____ chronic pain
____ fatigue
____ sleep disorders
____ other _____

Reproductive

____ PMS
____ pregnant? trimester ____
____ other _____

Other

____ diabetes
____ eating disorders
____ depression
____ drug / alcohol addiction
____ nicotine / caffeine addiction
____ other _____

Information needed before using Ultrasound or Low Level Laser (Phototherapy)

___ Have you ever had or have cancer (tumors or cancerous areas?
___ Do you have any photo sensitivities (sensitive to light)?
___ Are you currently pregnant or nursing?
___ Do you have a pacemaker?
___ Are you taking any Immune suppressive drugs?
___ Are you taking any Anticoagulants?
___ Are you taking any Anti-inflammatory medications?
___ Have you had a cortisone or botox shot in the last 10 days?

Activities of Daily Living

In this section, the idea is to get a sense of what type movements and to what intensity and frequency of activities/movements, postures/positions, and exercise you get a regular basis.

Job/Work Duties: _____

Household Duties: _____

Regular Activities/Hobbies: _____

Exercise: _____

Sleeping Position: _____

Other Activities: _____

What do you believe caused or is causing this condition? _____

_____

Do you believe it is possible to heal 100%? If not, what percentage? _____

How long do you feel it will take? _____

The level of stress you are experiencing on a regular basis on a scale of 1 to 10

(1 being the lowest): (mild 1-3, moderate 4-7, severe 8 – 10) __

Release and Indemnification

I hereby authorize The Center for Clinical Massage to provide any and all information, copies or records to any clinic, physician, lawyer, insurance company, or workman's compensation fund as deemed necessary. A copy of this authorization shall be considered as valid as the original.

I hereby authorize any physician to release any and all information, copies of all records to The Center for Clinical Massage as deemed necessary for treatment. A copy of this authorization shall be considered as valid as the original.

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I also understand that this office will prepare any necessary reports to assist me in making a collection from this insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for payment.

Printed Name_____ Date_____

Signature_____

Signature (Guardian if under 18) _____