Knewtson Health Group

New Patient Massage

Please take a moment to answer the following questions. The information you provide will be used to customize your session to your needs, exclude any techniques that may be medically unsuitable for you, and may be used, while protecting your privacy.

Name_____ **Date of Birth**_____ Male ☐ Female ☐

Address_____ **City/State/Zip**_____

Phone (H)_____ **(C)**_____ Occupation_____

Referred By: _____ Emergency Contact & Phone: _____

E-mail_____ Have you been seen at Knewtson Health Group before? ☐ Yes ☐ No

Current Medications/OTC/Supplements & WHY: _____

_____

Please answer the following to the best of your knowledge.

1. Have you had a professional massage before? ☐ Yes ☐ No
2. Do you have allergic reactions to oils, lotions, or other substances put on your skin, or to any nuts? ☐ Yes ☐ No
3. Do you have any particular goals for this massage session? _____
4. If you are currently under medical supervision, please explain_____
5. Please check any condition/symptom listed below that applies to you:

Musculoskeletal System
- ☐ Artificial Joint
- ☐ Baker's Cyst
- ☐ Bursitis
- ☐ Fibromyalgia or CFS
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Plantar Fasciitis
- ☐ Rheumatoid Arthritis
- ☐ Tendonitis
- ☐ Whiplash
- ☐ Other _____

Nervous System
- ☐ Alzheimer's
- ☐ Herpes Zoster/Shingles
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Spinal Cord Injury
- ☐ Numbness
- ☐ Other_____

Circulatory System
- ☐ Atherosclerosis
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Leukemia
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Other_____

Digestive System
- ☐ Crohns
- ☐ IBS
- ☐ Ulcers
- ☐ Ulcerative Colitis
- ☐ Other_____

Lymph/Immune System
- ☐ Allergic Reactions
- ☐ Chronic Fatigue
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Lymphoma
- ☐ Other_____

Respiratory System
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Sinusitis
- ☐ Other_____

Integumentary System (Skin)
- ☐ Athlete's Foot
- ☐ Boils
- ☐ Burns
- ☐ Cold Sore/Herpes
- ☐ Dermatitis
- ☐ Impetigo
- ☐ Open Sores/Wounds
- ☐ Psoriasis
- ☐ Rashes
- ☐ Warts
- ☐ Other_____

Miscellaneous Conditions
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ Headaches
- ☐ Migraines
- ☐ Numbness
- ☐ **Pregnant**

Due Date_____
- ☐ Other_____

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6. Please list any accidents or operations you have had and dates: _____

_____

7. Please list any Sports/Regular Physical Activities **you do:**

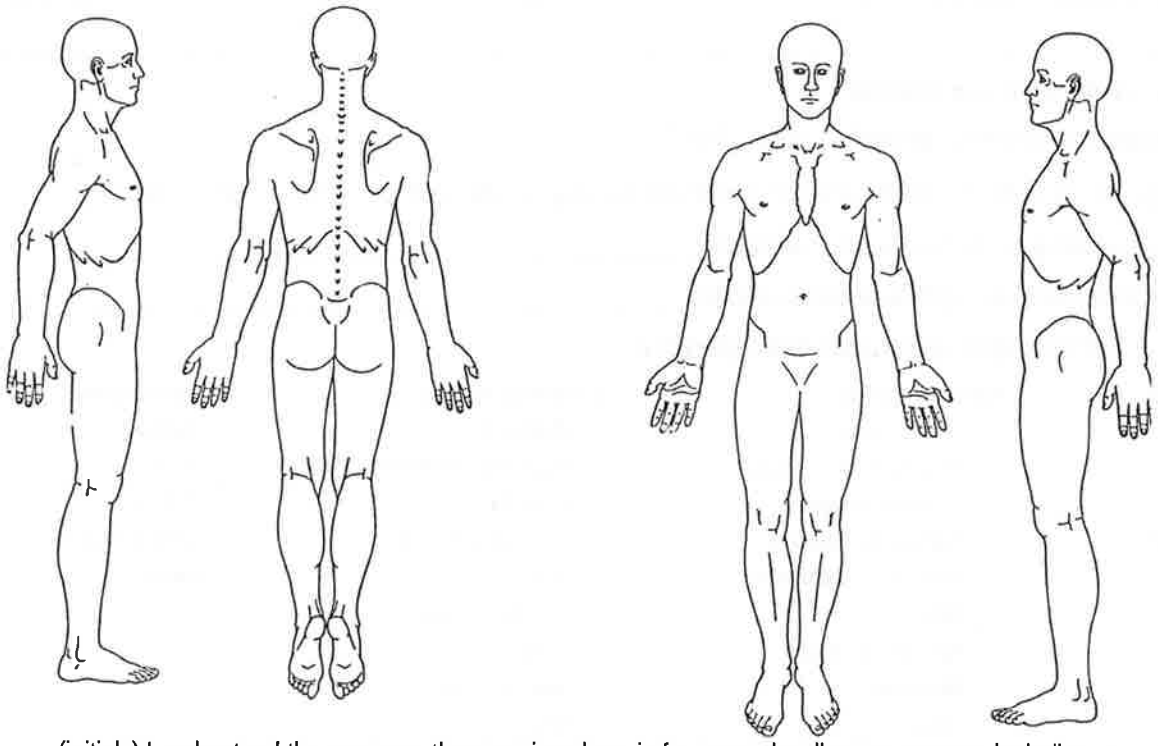
Cards	Running	Tennis	Quilting
Gardening	Volleyball	Walking	Swimming
Golf	Bowling	Lift Weights	Other: _____

8. Please circle the level of physical activity you do:

None Light Moderate Heavy

9. Please mark on the body forms with an **"X"** where you are experiencing any tension, stiffness or other discomfort. Please describe the sensation (burning, stinging, aching, pins/needles, etc.):_____

_____



_____ (initials) I understand the massage therapy given here is for general wellness purposes, including stress reduction, relief from muscular tension or spasm, the promotion of circulation, lymph activity, and flexibility. I understand a massage therapist will never touch genitals, breast tissue, or any other areas I instruct them not to touch. I understand massage therapists do not diagnose illness, disease, or any other physical or mental disorder, do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I also understand that it is my responsibility to inform the massage therapist of any existing medical conditions I may have, and keep the massage therapist informed of any changes in my health and medications in the future. I understand that potential risks of massage include: mild, short term muscle soreness due to movement of irritating metabolic wastes and mild surface level bruising. I understand I have the right to refuse massage therapy treatment at any time during the session. I authorize the performance of massage therapy techniques.

Signature_____ Date_____

I understand that I may be refused treatment if I appear intoxicated or under the influence of drugs.

Signature_____ Date_____

Knewtson
Health Group

Office Fees- Massage Therapy

In effort to create open communication with our patients we would like to inform you of your office fees up front.

Cancellations:

Cancellations must be made 24 hours in advance or you will be responsible for the full price of your massage.

In some cases massage therapy charges are billed to your insurance (MVA, W/C and PI only). Please keep in mind that all cancellation fees are billed directly to the patient and *are not* submitted to insurance. We strongly advise you to call your insurance company to verify your eligibility and coverage. PLEASE REMEMBER massage therapy is not submitted to personal private health insurance by Knewtson Health Group.

I have read the Knewtson Health Group office policy regarding fees for massage therapy and understand that all fees are due upon receipt and before your next service is provided.

I acknowledge the cancellation policy and will adhere to this policy.

Patient Signature: _____ Date: _____

KHG Staff: _____ Date: _____