INITIAL EVALUATION /ASSESSMENT

PATIENT: _____

Address: _____ State: _____ Zip:_____

DATE OF BIRTH: _____ HOME PH: _____

OCCUPATION: _____ WORK PH: _____

HOW LONG: _____ EMAIL ADDRESS: _____

SPOUSE: _____ SPOUSE WORK #: _____

INSURANCE: NAME OF COMPANY: _____

Date of Incident _____ GROUP: _____

CLAIM / POLICY #: _____ REF BY: _____

S. S. #: _____ ADJUSTER_____

DOCTOR: _____ **ATTORNEY: _____**

PHONE #: _____ PHONE: _____

ADDRESS: _____ **ADDRESS:** _____

CITY: _____ CITY: _____

STATE: _____ ZIP: _____ STATE: _____ ZIP: _____

EMPLOYER: _____

COMPANY: _____PHONE: _____

SUPERVISOR: _____

ADDRESS: _____CITY: _____ ST: _____ ZIP:_____

NOTIFY/ EMERGENCY: _____PHONE: _____

Nearest relative, not living with you? _____

Relationship: _____ Phone: _____

HOW WILL PAYMENT BE MADE?

AUTO INSURANCE: ☐ WORKERS' COMPENSATION: ☐ MAJOR MEDICAL: ☐ CASH: ☐

ATTORNEY LIEN: ☐ CREDIT CARD: ☐ CHECK: ☐ OTHER: ☐ How?_____

CREDIT CARD: TYPE: _____CARD #_____

EXP. DATE: _____ CV Code: (3 #'s on back or 4#'s front of AMEX_____

Address used for CC Billing: _____ State_____ Zip_____

INITIAL EVALUATION /ASSESSMENT

- Was this case related to Work ☐ Auto ☐ or Other ☐ Explain _____

♦ How did it happen? _____

♦ If it happened at work, was the employer notified? Yes ☐ No ☐

♦ Has the insurance company been notified? Yes ☐ No ☐

♦ Are you presently employed? Yes ☐ No ☐

♦ Occupation: _____

♦ If work related, are you working for same employer? Yes ☐ No ☐

♦ Are you presently under a doctor's care? Yes ☐ No ☐

♦ Have you ever been treated for the same condition? Yes ☐ No ☐

♦ Were you admitted to the hospital? Yes ☐ No ☐ How long? _____

♦ What makes your condition worse? _____

♦ Surgery in past 4 years Yes ☐ No ☐ If yes, Explain:_____
_____
_____

♦ Smoke Yes ☐ No ☐ Use alcohol, Yes ☐ No ☐ Tea Yes ☐ No ☐Caffeine Yes ☐ No ☐

Coffee Yes ☐ No ☐ **Chocolate** Yes ☐ No ☐ **Eat red meats** Yes ☐ No ☐

♦ If female, are you pregnant Yes ☐ No ☐ Date due:_____ Wear Contacts Yes ☐ NO ☐

♦ High blood pressure Yes ☐ No ☐ If yes, approximately your latest reading? _____ /_____
♦ Contagious Diseases Yes ☐ No ☐ If yes, explain _____
♦ Heart Condition Yes ☐ No ☐ If yes, Explain_____
♦ Wear Contacts Yes ☐ No ☐
♦ Varicose Veins Yes ☐ No ☐ Where? _____
♦ Cancer Yes ☐ No ☐ If yes, Location? _____

List 3 major health complaints and medications you are taking: (use back of form if necessary)

1. _____
2. _____
3. _____

Medications_____

Do you have any family history, preexisting conditions or possible medical contraindications that might cause concern or that would affect your present injury, illness or other medical conditions such as diseases, implants, surgeries, etc? YES__ NO ____If YES, please explain: **Use Back of Form**_____

I hereby grant permission to the massage therapist(s) at this facility to provide massage therapy services to me. I acknowledge that if I am not satisfied with said services I am free to go elsewhere. I have a right to a copy of my medical records if requested. *(I realize that copy charges may apply.)* I understand that I am receiving my physician prescribed health care related massage therapy services by a trained, licensed and/or certified massage therapist. I understand that a massage therapist, under no circumstance, is allowed to diagnose or offer a prognosis of my medical condition.

Patients or Legal Representative: _____ Date: _____

INITIAL EVALUATION /ASSESSMENT

PATIENT: _____**DATE:** _____

CLAIM #:_____ **S. S. #:**_____

Date of injury or illness: _____

SUBJECTIVE: (Patient's Primary or Chief Complaint.)

_____
_____
_____
_____
_____
_____
_____

OBJECTIVE: (What the therapist sees and finds in initial evaluation /assessment and how it directly and casually relates to injury or illness.)

_____
_____
_____
_____
_____
_____
_____

ASSESSMENT/ Evaluation: (Treatment procedures provided, functional outcome from current treatment and how therapist assesses patients condition after treatment.)

_____
_____
_____
_____
_____
_____
_____

PLAN OF CARE: What therapist plans to do, treatment to be provided and goals set during treatment session that will achieve further positive functional outcome for patients diagnosed medical condition. What therapist and patient can expect from current and future therapy sessions to be provided.

_____
_____
_____
_____
_____
_____
_____

SUGGESTIONS: **(home self care, etc.**)

_____
_____
_____
_____

OTHER DOCUMENTATION:

_____
_____