Patient Information

Date: _____
Patient: _____
DOB: ___/____/____ SSN: _____-____-_____
☐ Female ☐ Male Height: _____Weight: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _____
Employer: _____
Employer Address: _____
Employer Phone: _____

Whom May we Thank for referring you? _____
_____

In case of Emergency

Name: _____Relationship: _____
Phone: _____ Work: _____
Would you like email flyers/discounts? ☐ Yes ☐ No
Email: _____

Insurance

Who is responsible for this account? _____
Relationship to patient: _____
Insurance Co: _____ ID#: _____
Insurance Address: _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

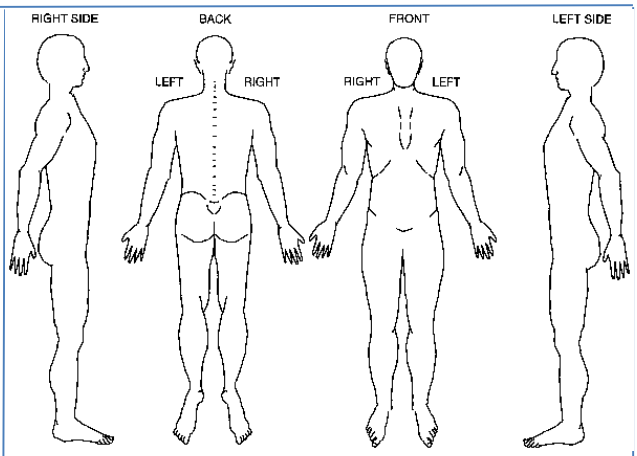
and assign directly Erik C Sipfle, LMT all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. If the

account balance goes to collections, I understand that I am responsible for any and all collection fees. I hereby auth Erik C Sipfle, LMT to release all information necessary to secure payments from insurance I authorize the use of this signature on all insurance and claim and if the account balance goes to collections.

Responsible Party Signature: _____
Relationship: _____ Date: _____

Patient Condition:

Reason for visit: _____
When did you symptoms appear: _____
Is this condition getting progressively worse: ☐ yes ☐ no
Rate severity of pain on a scale 1 (least) to 10 (severe): _____
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Ache ☐ Stiffness ☐ Burning ☐ Cramps ☐ Shooting
☐ Swelling ☐ Tingling ☐ Other: _____
How often do you have pain: _____
Is it consistent or does it come and go: _____
Are you working: ☐ yes ☐ no
Does it interfere with: ☐ work ☐ sleep ☐ daily life ☐ recreation
Activities or movements that are painful: ☐ sitting ☐ standing
☐ walking ☐ bending ☐ lying down ☐ kneeling



Shade in the area(s) on the picture where you continue to have pain, numbness or tingling.

☐ Check if not workers compensation or no-fault

Accident Information

Is this condition due to a: ☐ No-fault ☐ workers compensation if yes date of injury: _____
Do you have an attorney: ☐ yes ☐ no if yes whom, _____ Phone: _____

If no-fault Name of Insurance: _____
Address: _____
City: _____ ST: _____ Zip: _____
Phone: _____
Name of Insurance#: _____

If workers comp Name of carrier: _____
Address: _____
City: _____ ST: _____ Zip: _____
Phone: _____
Address: _____

Other information you would like us to be aware of before your massage: _____
_____
_____
_____

Massage Informed Consent

I hereby request and consent to the performance of massage therapy and other massage therapy procedures, including various modes of physical therapy and modalities on me (or on the patient named below, for whom I am legally responsible) by the licensed massage therapist named below.

I understand that results are not guaranteed and that massage therapy is not intended as a substitute for a medical examination and is not designed to diagnose a medical condition, offer medical treatment or prescribe medications. I understand that a massage should not be done when certain medical conditions exist, and I have informed the therapist of my current medical condition. I am informed that, as in the practice of medicine, in the practice of massage therapy there are some risks to treatment. I do not expect the therapist to be able to anticipate and explain all the risks and complications, and I wish to rely on the therapist to exercise judgment during the course of the massage which the therapist feels at the time, based on the facts then known to the therapist, is in my best interest. I acknowledge that I need to tell the therapist if the pressure or stokes are too hard or cause pain.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand that if I cannot keep my appointment that I will call to reschedule as soon as possible. I also agree and understand that if I no-show to an appointment that I will be charged a $25.00 no-show fee, at therapist's discretion, which is not reimbursable through my insurance and will be paid prior to any upcoming appointment. Should my account go to collections, I understand that I may be charged a 35% collection fee on my outstanding balance.

Patient Signature: _____ Date: _____

Patient/Guardian Signature: _____Date:_____

Erik Sipfle, LMT

LMT Signature: _____ Date: _____

*Have you had a massage in the past?*_____

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage?

_____

How do you feel today?

_____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

Do these symptoms interfere with your daily living (e.g. sleep, exercise, work, childcare, etc.) Yes No
Explain:

_____

List the medications you currently take:

_____

Are you wearing contacts? ☐ *Yes* ☐ *No*
Are you wearing dentures? ☐*Yes* ☐ *No*
Are you wearing a hairpiece? ☐*Yes* ☐ *No*
Are you pregnant? ☐ *Yes* ☐ *No*

Health History:
Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

CHECK ANY of the following health conditions that you currently have (if you are unsure please ask):
☐ *Blood Clots* ☐ *Infections* ☐*Congestive heart failure* ☐*Contagious Diseases* ☐*Pitted Edema*

PLEASE INDICATE conditions that you have or have had in the past. Explain in detail, include previous treatment

☐*Current* ☐*Past* *Muscle or joint pain* _____
☐*Current* ☐*Past* *Muscle of joint stiffness* _____
☐*Current* ☐*Past* *Numbness or tingling* _____
☐*Current* ☐*Past* *Swelling* _____
☐*Current* ☐*Past* *Bruise easily* _____
☐*Current* ☐*Past* *Sensitive to touch/pressure* _____
☐*Current* ☐*Past* *High/Low Blood Pressure* _____
☐*Current* ☐*Past* *Stroke/Heart Attack* _____
☐*Current* ☐*Past* *Varicose Veins* _____
☐*Current* ☐*Past* *Shortness of breath, asthma* _____
☐*Current* ☐*Past* *Cancer* _____
☐*Current* ☐*Past* *Neurological (e.g. MS, Parkinson's, chronic pain* _____
☐*Current* ☐*Past* *Epilepsy, Seizures* _____
☐*Current* ☐*Past* *Migraines/Headaches* _____
☐*Current* ☐*Past* *Dizziness, ringing in ears* _____
☐*Current* ☐*Past* *Digestive Conditions* _____
☐*Current* ☐*Past* *Gas, Bloating, constipation* _____
☐*Current* ☐*Past* *Kidney/Gallbladder/Prostate* _____
☐*Current* ☐*Past* *Arthritis/rheumatoid/osteo* _____
☐*Current* ☐*Past* *Scoliosis* _____
☐*Current* ☐*Past* *Broken Bones* _____
☐*Current* ☐*Past* *Allergies* _____
☐*Current* ☐*Past* *Diabetes* _____
☐*Current* ☐*Past* *Endocrine/Thyroid* _____
☐*Current* ☐*Past* *Depression/anxiety* _____
☐*Current* ☐*Past* *Memory Loss, confusion, easily overwhelmed* _____