Mark Wallace, Licensed Massage Practitioner (206) 396-8452

Washington State Department of Health: Massage Practitioner License # MA 60197801

*** PLEASE MAKE CHECKS PAYABLE TO KMW, LMP ***

Manual Therapist

HEALTH INFORMATION

Patient Name: ______________________ Date: ______________

Date of Injury: ______________________ ID#/DOB: ______________

A. Patient Information

Address ______________________

City/State/Zip ______________________

Phone: Home ______________________

Work ______________ Cell ______________

Employer ______________________

Work Address ______________________

Occupation ______________________

Emergency Contact ______________________

Phone: Home ______________________

Work ______________ Cell ______________

Primary Health Care Provider

Name ______________________

Address ______________________

City/State/Zip ______________________

Phone ______________ Fax ______________

I give my massage therapist permission to consult with my health care providers regarding my health and treatment.

Comments ______________________

Initials __________ Date ______________

B. Current Health Information

List Health Concerns (check ALL that apply):

Primary ______________________

☐ mild ☐ moderate ☐ disabling ☐ constant ☐ intermittent

Symptoms: ☐ ↑ w/activity -OR- ☐ ↓ w/activity

☐ getting worse ☐ getting better ☐ no change

Treatment received ______________________

Secondary ______________________

☐ mild ☐ moderate ☐ disabling ☐ constant ☐ intermittent

Symptoms: ☐ ↑ w/activity -OR- ☐ ↓ w/activity

☐ getting worse ☐ getting better ☐ no change

Treatment received ______________________

Additional ______________________

☐ mild ☐ moderate ☐ disabling ☐ constant ☐ intermittent

Symptoms: ☐ ↑ w/activity -OR- ☐ ↓ w/activity

☐ getting worse ☐ getting better ☐ no change

Treatment received ______________________

List Daily Activities Limited by Condition

Work ______________________

____

Home/Family ______________________

____

Sleep/Self-care ______________________

Social/Recreational ______________________

List Self-Care Routines

How do you reduce stress? ______________________

____

Pain? ______________________

____

List all current medications (include pain relievers and herbal remedies) ______________________

____

____

Have you ever received massage therapy before? Yes ______ No ______

How often? ______________________

What are your goals for receiving massage therapy? ______________________

____

____

C. Health History

Please list and explain. Include dates and treatments received.

Surgeries ______________________

____

____

Injuries ______________________

____

____

Major Illnesses ______________________

____

____

______________________, ____/____/________

PATIENT SIGNATURE DATE

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