Therapeutic Bodywork LLC

New Client Intake and Evaluation Form

Today's Date:_____ Last Name:_____

Personal Information (please write above each line)

_____/__/____
name date of birth

_____
address

_____
city state zip

_____/_____
phone # (mobile/home)

_____
e-mail

_____
occupation

_____/_____/_____
emergency contact relationship phone#

Referred By:_____

Massage Experience

Have you had a professional massage before? Y / N

If yes, when was your last massage?_____

How often do you receive massage?_____

Current Health

Reason for initial visit:_____

_____

_____

Height & Weight: _____

Do you exercise or play sports regularly? Y / N

If yes, describe:_____

Do you perform repetitive movements in your work sport or hobby? Y / N If yes, describe:_____

_____

Do you sit for long hours at a workstation, computer or driving? Y / N If yes, how many hours?:_____

Are you experiencing tension, stiffness, discomfort or pain? Y / N If yes, describe:_____

_____

_____

Have you recently had an injury, surgery or area(s) of inflammation? Y / N If yes, describe:_____

_____

_____

Please list any allergies:_____

_____

Please list any medications you are currently taking:_____

_____

Have you ever been treated for cancer? Y / N If yes, please describe:_____

_____

Health History (please check all that apply)

	Bone or Joint disease		Tendonitis/bursitis
	Arthritis/Gout		Jaw Pain (TMJD)
	Lupus		Scoliosis
	Headaches/Migraine		Osteoporosis
	Heart Condition		Phlebitis/Varicose Veins
	Blood Clots		High/Low Blood Pressure
	Lymphedema		Thrombosis/Embolism
	Breathing Difficulty/Asthma		Implanted Medical Device
	Sinus Problems		Shingles
	Numbness/Tingling		Pinched Nerve
	Chronic Pain		Paralysis
	Multiple Sclerosis		Parkinson's Disease
	Pregnant, week____		Menstrual Problems
	Prostate Problems		Cosmetic Surgery
	Athlete's Foot		Emphysema
	IBS		Bladder/Kidney Ailment
	Colitis		Crohn's Disease
	Ulcers		Anxiety
	Depression		Diabetes
	Contact Lenses		Hearing aid

Other medical history or condition(s), surgeries or injuries not listed above:_____

_____

_____

_____

_____

Are you receiving other medical care? Y/N, if Yes, please list the name of your care provider(s):_____

_____

_____

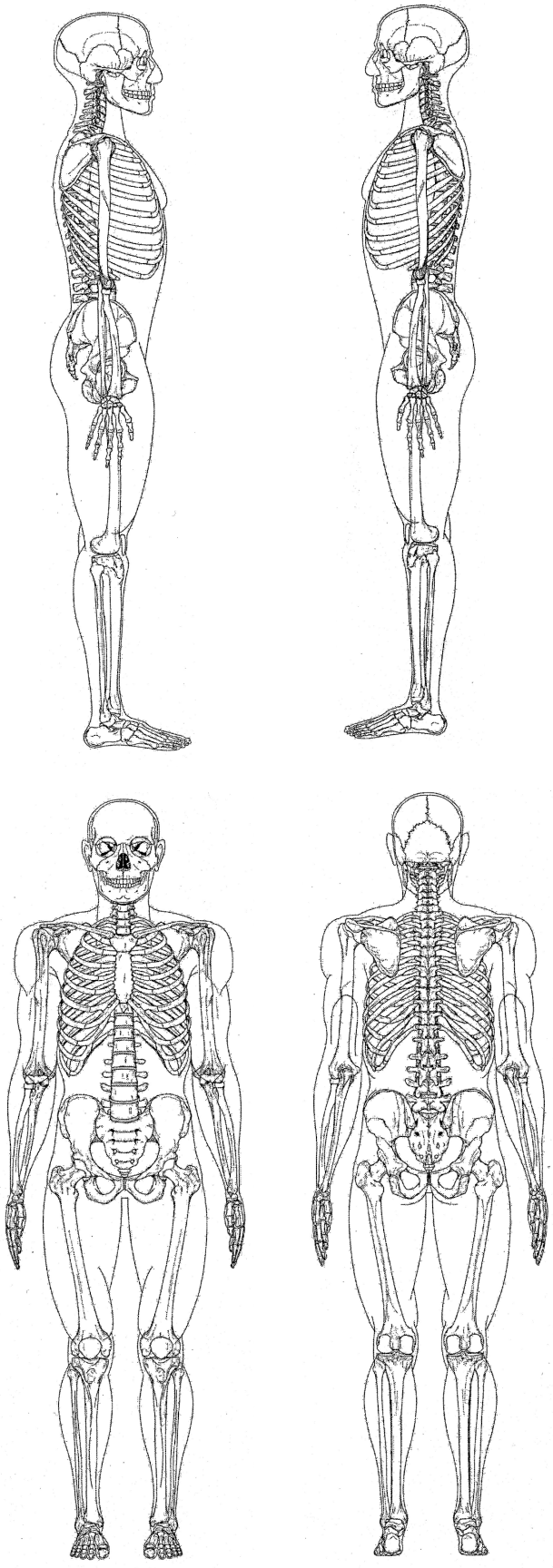
_____

Therapeutic Bodywork LLC

New Client Intake and Evaluation Form

Today's Date:_____ Last Name:_____

S	Hist Pain W/W Act Perp Goals:
O	AROM PROM MRT Palp Obsv Tests
A	DX from Physician/Chiropractor/PT:_____ _____ Impressions_____ _____ Tissues involved_____ _____
P	CPT 97124 Massage Therapy:_____ CPT 97140.XS or.54 TPT/MFR:_____ CPT 97010 Hot/Cold Packs:_____ CPT 97110 PNF:_____ CPT 99212 Final Eval/Release_____ CPT 97161 Initial Eval/Intake_____ CPT 97164 Re-eval_____ Plan#/freq_____ _____ _____ _____



www.therabodywork.com **ph**:702-505-1494 **fax**:7026758073 **email**: ryan@therabodywork.com
NPI#:1043690852 **NVMT**:3291