Welcome **to the** ***Alternative Therapy Center***

CONFIDENTIAL QUESTIONNAIRE

Please Print and Fill Out Both Sides of Form:

Name________________________________ Home Phone________________ Work Phone ________________

Address____ City__________________ State_____ Zip__________

Date of Birth______________ Age_______ M___ F___ Height____ Weight___ Occupation______________________

Have you ever received a Professional Massage before? Yes___ No___ Referred By______________________

PRESENT COMPLAINTS ____

____

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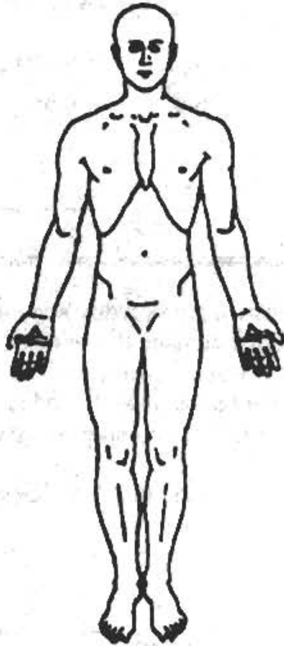
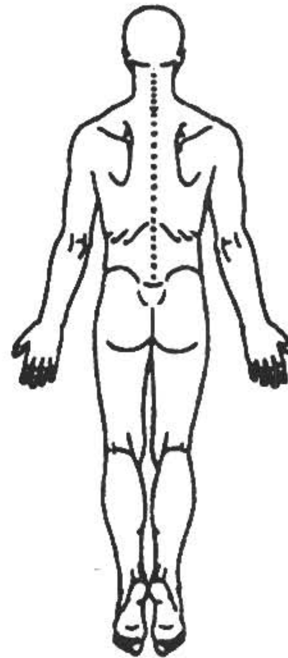
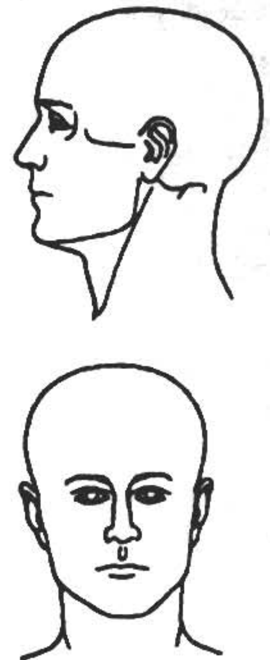
Please Mark Areas of Pain, Discomfort or Concern:







Please Check if you Have any of these Conditions at the Present Time:

__High Stress
__Recurring Headaches
__Tight Neck
__Grating in Neck
__Neck Pain
__Head feels Heavy
__Fatigue
__Dizziness
__Fainting
__Loss of Balance

__Disc Problems
__Muscles Spasms
__Cold Arms/Hands
__Cold Legs/Feet
__Tight Shoulders
__Numbness or Tingling
__Pain in Arms/Hands
__Pain in Legs/Feet
__Low Back/Hip Pain
__Knee/Ankle Pain

__Arthritis
__Diabetes
__Skin Cancer
__Other Cancer
__ Kidney Disease
__Allergies
__Abdominal Pain
__Digestive Problems
__Constipation
__Edema

__Heart Problems
__Shortness of Breath
__High Blood Pressure
__Low Blood Pressure
__Skin Problems
__Bruise Easily
__Varicose Veins
__Blood Clots
__Wear Contacts
__Wear Dentures

Please List any Other Medical Conditions:____

____

Please List any Prescribed Medications:____

____

Please List and Date all Prior Operations: ____

____

Please List and Date all Injuries/Accidents: ____

____

Please List and Date all Broken Bones: ____

____

Please List Activities that Aggravate Your Condition: ____

____

Please Check if your Condition Interferes with: ____ Work ____ Sleep ____ Regular Activities ____ Exercise Routine

Please Describe Exercise Routine: ____

____

Please Describe with (Heavy, Moderate, Light, None) **Consumption of the Following:** Pain Killers______ Sleeping Pills______

Sedatives_____ Alcohol_____ Tobacco_____ Sodas_____ Coffee_____ Sugar_____ Fried Food______ Breads______ Cereals______

Meats______ Fish______ Dairy______ Nuts______ Fruits______ Vegetables______ Vitamins______ Minerals______ Herbs______

Further Comments: ____

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Please Read and Sign the Following: MASSAGE THERAPY is intended for the relief of muscle tension, stress reduction, and to assist venous and lymphatic circulation. MASSAGE THERAPISTS do not diagnose, prescribe medication, or manipulate the spine.
IT IS THE CLIENT'S RESPONSIBILITY to provide pertinent health information and to inform the therapist of any changes.
I, the undersigned, agree that the massage services provided by a Licensed Massage Therapist in this Establishment are provided pursuant to and in accordance with the laws of the State of Florida governing Massage Therapy and that full and complete medical history disclosure is essential in providing such therapy.
I also understand that payment is due at time of treatment, unless other arrangements are made. I also understand that I am responsible for payment if the third party payment is not received.

SIGNED: ____ **DATE:** ____________________

TO PREVENT BEING CHARGED, PLEASE GIVE 24 HRS. NOTICE OF CANCELLATION

If your Doctor has prescribed treatment, please complete the following in order to process your claim.

~ You must have a prescription and coverage must be verified before treatment.

Name of Doctor: ______________________________ **Phone Number:** ____________________
Address: ______________________________ **City:** ____________________ **State:** ______ **Zip:** ___
Doctor's Diagnosis: ____
How are you responding to your present course of treatment? **Better**______ **Worse** ______ **Same**______

INSURANCE INFORMATION

Name of Company: ______________________________ **Phone Number: 1-800** ____________________
Address: ______________________________ **City:** ____________________ **State:** ______ **Zip:** ___

Name/Ext. # of Adjuster: ______________________________ **Date of Accident:** ____________________

Policy # ______________________________ **Claim#** ____________________

SS#_______-_______-_______ **PIP**_____ **WC**_____ **Amt. of Deductible**________ **% of Coverage**________