## Mollie M. Ferreira, LMT MAT 5722 dba Essential Massage Therapy

# REGISTRATION FORM

|  |
| --- |
| (Please Print) |
|  Today’s date: |  |
|  Client INFORMATION |
| Client’s last name: | First: | Middle: | ❑ Mr.❑ Mrs. | ❑ Miss❑ Ms. | Marital status (circle one) |
|  | S / Mar / Div. / Sep / W |
| Is this your 1st massage? | When was your last Massage? | Who worked on you? | Birth date: | Age: | Gender |
| ❑ Yes | ❑ No |  |  |  / / |  | ❑ M | ❑ F |
| Mailing address: | City: | Home phone no.: |
| Physical addressE-mail |  | Cell phone no. |
|  | Preferred method of communication  | State: | ZIP Code: |
|  |  |  |  |
| Occupation: | Employer: | Employer phone no.: |
|  |  | ( ) |
| Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Dr. |  |  |   |
| ❑ Family | ❑ Friend | ❑Online | ❑ Yellow Pages | ❑ Other |  |
| Other family members seen here: |  |
|  |
| about you |
| Are there any areas you don’t want me to work on? |  | What is your chief complaint or area you want to improve? | What is your goal for this visit? |
|  |   |  |  |
| When did you first notice chief complaint? |   |  |  What brought it on? |  |
| What aggravates it? | Is it getting worse? | Does it interfere with | What have you done to get relief? |
|  |  | Work? Sleep? Daily routine? |  |
| Has there been a medical diagnosis?  |  |  |  |
|  Are you under medical treatment for any condition?  | What? |  |  |  |  |
| Who is treating you? |  |  |  Do I have permission to discuss treatment with them?  |  |  |
| List medications and supplements you’re taking. |  |  |  |  |  |
| Describe your exercise activities and frequency: | List accidents / operations |  |  |
|  |
| IN CASE OF EMERGENCY |
| Name of local friend or relative  | Relationship to patient: | Home phone no.: | Work phone no.: |
|  |  | ( ) | ( ) |
|  |  |  |  |  |

**Health History**

Please indicate the conditions that apply to you, past and present.

Musculo-Skeletal Skin Reproductive System

Headaches rashes pregnancy past / present

Joint stiffness / swelling allergies PMS

Spasms / cramps athletes foot menopause

Broken bones warts Pelvic inflammatory disease

Strains / sprains moles endometriosis

Back pain; upper / lower acne hysterectomy

Hip pain nail fungus fertility concerns

Shoulder / neck pain other prostate problems

Elbow / wrist / hand pain

Problems walking Digestive Other

Chest / rib / abdominal pain nervous stomach forgetfulness

Jaw / TMJ pain indigestion confusion

Tendonitis constipation depression

Bursitis gas / bloating difficulty concentrating

Arthritis diarrhea hearing impaired

Osteoporosis diverticulitis visually impaired

Scoliosis irritable bowel syndrome bladder infection

Bone or joint disease crohn’s disease infectious disease

 Eating disorder

Circulatory & Respiratory Nervous System diabetes

High / low blood pressure numbness / tingling fibromyalgia

Blood clots / DVT twitching of face post-polio syndrome

Varicose veins fatigue cancer

Lymphedema chronic pain Alzheimer’s

Asthma / emphysema sleep disorders vertigo / motion sickness

Sinus problems / allergies ulcers Aids / ARC

Heart condition paralysis congenital or acquired disability

Stroke herpes / shingles autoimmune disorder

Swollen ankles cerebral palsy Muscular dystrophy

Cold sweats epilepsy

Cold feet or hands chronic fatigue syndrome CRS

Fainting / dizziness multiple sclerosis

COPD Parkinson’s

The above information is true to the best of my knowledge. I will inform you of any change in my health status. I understand that there will be no sexual interaction between practitioner and client, I understand the practitioner has the right to terminate the massage at their discretion and receive payment in full. I authorize my insurance benefits be paid directly to the practitioner. I understand that I am financially responsible for all charges. I also authorize Mollie M. Ferreira, LMT MAT 5722 dba Essential Massage Therapy or insurance company to release any information required to process my claims.

Client/Guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_