Health History

Areas of pain or discomfort :

How did it happen?

Since the injury are your symptoms:
☐ Worse ☐ Improving ☐ Changing (If changing, explain):
What makes the condition worse?

What area did you feel pain in immediately after the accident?

During daily work or activities, do you have to favor any part of your body? **Yes - No**
If yes, explain:

Are you currently employed? **Yes - No**
Occupation:

Have you ever been treated for the same condition? **Yes - No**
If yes, explain:

Any surgery in the past 4 years? **Yes - No**
If yes, explain:

Do you have any pre-existing conditions that might cause concern or that relate to your present injury or illness? **Yes - No**
If yes, explain:

Any other condition that might be aggravated by Massage Therapy? **Yes - No**
If yes, explain:

If female, are you pregnant? **Yes - No**

Do you:	smoke	use alcohol
drink tea or coffee	eat chocolate	eat red meat

Do you have:	any Contagious Diseases	High BP
Heart Condition	Varicose Veins	Wear Contacts

☐ WORK INJURY QUESTIONNAIRE

Have you ever injured this area before ? **Yes - No**
If yes, when?_____
Did you loose time from work at that time? **Yes - No**

Have you ever had a Workers' Compensation claim before? **Yes - No**

Do any other medical problems affect your employment? **Yes - No**

☐ **WC EMPLOYER AT TIME OF INJURY:** _____

ADDRESS: _____

CITY:_____ **ST** _____ **ZIP** _____

Did you return to work? **Yes - No**

For the same employer? **Yes - No**
If no, name of current employer: _____

Are you currently working? **Yes - No**
If no, last date of employment :____/____/_____

NAME:

DOB: ____/_____/_____ **SS#** ***-**-

INJ DATE: ____/_____/_____ **TIME** **AM - PM**

PHYSICIAN NAME: MD DO DDS DMD DC _____

PHONE: H: ( )____-_____ **FAX:** ( )____-_____

STATE OF OCCURRENCE: KY **OTHER :**

ANY DATES UNABLE TO WORK

FROM ___/___/20___ TO ___/___/20___

HOSPITALISTION?

FROM ___/___/20___ TO ___/___/20___

EMERGENCY ROOM VISIT?

DATE ___/___/20___

Are you presently under a doctor's care? **Yes - No**

Do you have any form of cancer? **Yes - No**
If yes, what type and where in the body ?

List three major health complaints:

List any medications you are currently taking:

EMERGENCY CONTACT: MR MRS MS DR REV _____

PHONE: ( )____-_____

Have you retained an attorney for this case? **Yes - No**

ATTORNEY: MR MRS MS _____

PHONE: ( )____-_____

ADDRESS: _____

CITY:_____ **ST**_____ **ZIP** _____

HOW WILL PAYMENT BE MADE? *Please check box(s)*

☐ AUTO INSURANCE	☐ WORKER'S COMP	☐ MAJOR MEDICAL	☐ ATTORNEY LIEN
☐ CASH	☐ CREDIT CARD	☐ CHECK	☐ OTHER

CREDIT CARD TYPE :_____EXP. DATE _____/_____
CARD # : _____

☐ AUTO INJURY QUESTIONNAIRE

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Were you struck from? ☐ Behind ☐ Front ☐ R Side ☐ L Side
If other, please explain:

Did you feel pain immediately?
If NO, when did you first start feeling pain?

Were you cited in the accident? **Yes - No - Unsure**

Do you have U/M (Uninsured Motorist Protection)? **Yes - No**

Do you have? **No Fault - PIP benefits - Med Pay**

INFORMATION ON DRIVER OF VEHICLE AT FAULT:

Name: _____ _ Phone:_____
Address_____
Ins. Co._____ Policy #:_____