TRUMOVE
BETTER HEALTH THROUGH MOTION

MASSAGE PATIENT INFORMATION Today's Date: _____ /_____ /_____

Patient Last Name: _____ First: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ - _____ Work Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

E-Mail Address: _____ Birth Date: _____ /_____ /_____ Sex: M | F

Emergency Contact: _____ Relation: _____ Phone: ( ) _____ - _____

If referred by a friend, please list his/her name:_____

CONSENT FOR CARE AND TREATMENT I, the undersigned, do hereby agree and give my consent for TruMove to furnish therapeutic massage to _____(Patient Name) as considered necessary and proper in treating his/her physical condition. I understand that a massage therapist diagnosis is not a medical diagnosis.

Patient or Guardian Signature_____Date_____

I understand and agree to comply with TruMove's Cancellation Policy. YES NO Initial _____

I have received a copy of TruMove's Notice of Privacy Practices. YES NO Initial _____

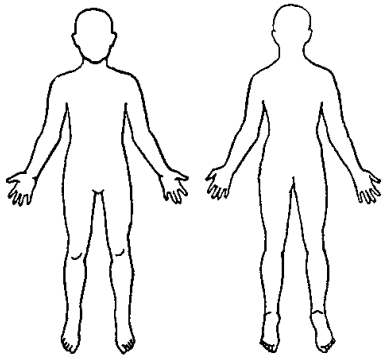
I understand and agree to comply with TruMove's Financial Policy. YES NO Initial _____

Are you currently being treated by a TruMove PT for this injury/condition? Y or N If so, which PT? _____

Do you now have or have you ever had any of the following**?**

- ❑ Asthma, Bronchitis, or Emphysema
- ❑ Shortness of Breath
- ❑ Chest Pain / Angina
- ❑ Coronary Heart Disease
- ❑ Pacemaker
- ❑ High Blood Pressure
- ❑ Heart Attack or Heart Surgery
- ❑ CVA (Stroke) / TIA (Mini Stroke)
- ❑ Blood Clot / Emboli
- ❑ Epilepsy / Seizures
- ❑ Thyroid Dysfunction / Goiter
- ❑ Anemia
- ❑ Infectious Diseases
- ❑ Diabetes
- ❑ Cancer / Chemotherapy / Radiation
- ❑ Arthritis / Swollen Joints
- ❑ Osteoporosis
- ❑ Gout
- ❑ Sleep Disorders
- ❑ Emotional / Psychological Problems
- ❑ Bowel and/or Bladder Dysfunction
- ❑ Severe or Frequent Headaches
- ❑ Vision or Hearing Difficulties
- ❑ Dizziness or Fainting
- ❑ Numbness or Tingling
- ❑ Weakness
- ❑ Unexplained Weight or Energy Loss
- ❑ Hernia
- ❑ Varicose Veins
- ❑ Allergies
- ❑ Any Pins or Metal Implants
- ❑ Joint replacement
- ❑ Neck Injury / Surgery
- ❑ Shoulder Injury / Surgery
- ❑ Elbow / Hand Injury / Surgery
- ❑ Back Injury / Surgery
- ❑ Knee Injury / Surgery
- ❑ Leg / Ankle / Foot Injury/ Surgery
- ❑ Are you Pregnant?
- ❑ Do you Smoke?

** **Please circle the area(s) of focus for today's massage** **



Please list any medications and/or comments:

_____

_____

_____