Alpine Therapeutic Massage

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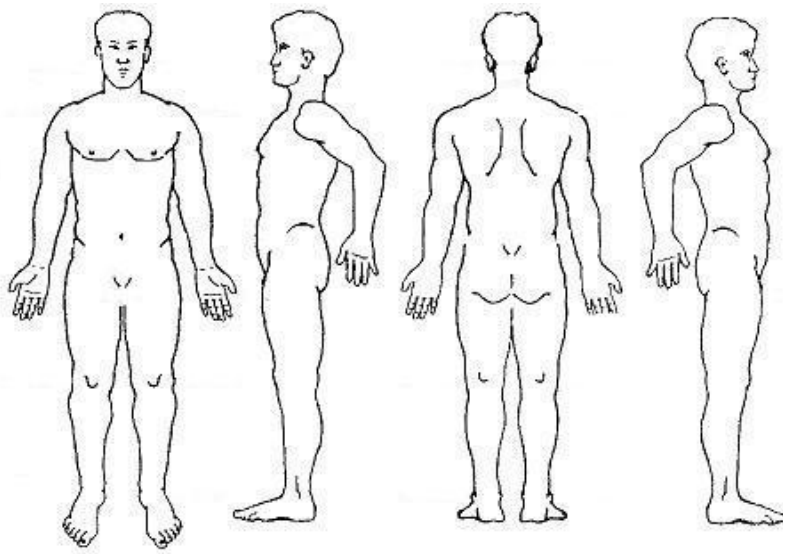

Mark an **X** on the diagram where you have pain or other symptoms.

Initial Health Status

Patient Name: _____

Describe your current problem: _____
_____

Date Problem Began: _____ This problem is a: ☐ Work Injury ☐ Automobile Injury ☐ N/A

Current complaint (how you feel today)

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%
Can you perform your daily activities? ☐ Yes ☐ No (Describe)_____
_____

Have you had spinal X-rays, MRI, CT Scan? ☐ No ☐ Yes
If yes, what did they indicate? _____
_____

Please check all of the following conditions that apply to you: ☐ None apply

Past	Present	Condition	Past	Present	Condition
☐	☐	Abdominal Pain	☐	☐	Frequent Urination
☐	☐	Abnormal Weight ☐ Gain ☐ Loss	☐	☐	High Blood Pressure
☐	☐	Alcohol Use	☐	☐	Low Back Pain
☐	☐	Allergies	☐	☐	Mid Back Pain
☐	☐	Aortic Aneurysm	☐	☐	Neck Pain
☐	☐	Arthritis	☐	☐	Pregnancy, number of births: _____
☐	☐	Birth Control Pills	☐	☐	Prostate Problems
☐	☐	Cancer (explain)_____	☐	☐	Scoliosis
☐	☐	Chest Pains	☐	☐	Stroke (date): _____
☐	☐	Diabetes	☐	☐	Fever
☐	☐	Dizziness/Fainting	☐	☐	Tobacco Use
☐	☐	Drug/Cortico Steroid	☐	☐	Tumor (explain) _____
☐	☐	Epilepsy/Seizures	☐	☐	Visual Disturbances
☐	☐	Excessive Thirst	☐	☐	Other: _____
☐	☐	Surgeries/Medications: _____			

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Strokes

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ **Date:** _____