

**The Center for Clinical Massage & Advantage Physical Therapy**  
24551 Raymond Way – suite 265, Lake Forest, CA. 92630  
949-510-4946

Initial Appointment Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

E-mail (office use only) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_

Marital Status:

Insurance Provider \_\_\_\_\_

Spouses Name (if applicable) \_\_\_\_\_

Spouses Occupation \_\_\_\_\_

How did you find out about us? \_\_\_\_\_

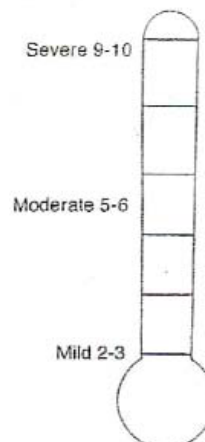
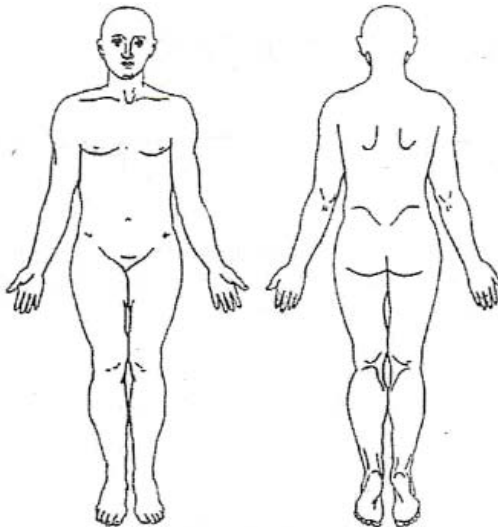
What is your reason for coming to see us today? \_\_\_\_\_

Where exactly is the problem? \_\_\_\_\_

Mark the figure below to specify your pain areas. (follow directions below or print form out)  
(go to tool bar at top of page and click on **comment**, click on **show comment & markup tool bar**)

Rate the recent level of pain by shading in the thermometer below.

Has it been getting Better or Worse?



Describe how it feels: aching, cramping, dull, sore, deep, sharp, shooting, stabbing, sting, tingling, burning, numbness, radiating – if so where? \_\_\_\_\_

How did it start the first time \_\_\_\_\_

If this is not the first time, how did it happen this time? \_\_\_\_\_

Was the onset (Sudden or Gradual)? \_\_\_\_\_

What movements were you doing at the time of injury? \_\_\_\_\_

How often does it bother you? (Constant all the time, everyday, \_\_\_x per week \_\_\_x per month)

How long does it last once it is there? (Always there, \_\_\_ hours/minutes\_\_\_\_, no pattern\_\_\_\_)

What specifically makes it worse?

(Certain movements/activities, stress, time of day, specific position standing/sitting, no pattern)

\_\_\_\_\_

What makes it feel better?

(Certain movements/activities, heat/ice, time of day, therapies, specific position standing/sitting, nothing)

\_\_\_\_\_

Do you have trouble sleeping due to pain? \_\_\_\_\_

What time of day do you have the most pain? \_\_\_\_\_

Do you have a diagnosis from a Doctor? \_\_\_

If, yes list it and name of the doctor.

Diagnosis \_\_\_\_\_ Doctor \_\_\_\_\_

Other therapies/remedies tried and results:

\_\_\_\_\_

Have you ever had any surgeries and were they beneficial at the time? \_\_\_\_\_

\_\_\_\_\_

List any other health problems for which you are being treated: \_\_\_\_\_

\_\_\_\_\_

Current Medications: ( including aspirin, ibuprofen, etc.) . \_\_\_\_\_

\_\_\_\_\_

Check the list below and check any condition that applies to you.

#### Muscular and Skeletal

- tendonitis
- bursitis
- broken / fractured bones
- arthritis
- sprains / strains
- low back, hip, leg pain
- neck, shoulder, arm pain
- headaches / head injuries
- spasms / cramps
- jaw pain / TMJ

#### Autoimmune System

- fibromyalgia
- lupus
- other \_\_\_\_\_

#### Circulatory System

- heart condition
- varicose veins
- blood clots
- high blood pressure
- low blood pressure
- lymph edema
- breathing difficulties
- sinus problems
- other \_\_\_\_\_

#### Skin

- allergies
- rashes
- athletes' foot
- warts
- other \_\_\_\_\_

#### Digestive System

- constipation
- gas / bloating
- diverticulitis
- irritable bowel syndrome
- other \_\_\_\_\_

#### Nervous System

- herpes / shingles
- numbness / tingling
- chronic pain
- fatigue
- sleep disorders
- other \_\_\_\_\_

#### Reproductive

- PMS
- pregnant? trimester \_\_\_\_
- other \_\_\_\_\_

#### Other

- diabetes
- eating disorders
- depression
- drug / alcohol addiction
- nicotine / caffeine addiction
- other \_\_\_\_\_

#### Information needed before using Ultrasound or Low Level Laser (Phototherapy)

- Have you ever had or have cancer (tumors or cancerous areas)?
- Do you have any photo sensitivities ( sensitive to light)?
- Are you currently pregnant or nursing?
- Do you have a pacemaker?
- Are you taking any Immune suppressive drugs?
- Are you taking any Anticoagulants?
- Are you taking any Anti-inflammatory medications?
- Have you had a cortisone or botox shot in the last 30 days?

## Activities of Daily Living

In this section, the idea is to get a sense of what type movements and to what intensity and frequency of activities/movements, postures/positions, and exercise you get a regular basis.

Job/Work Duties: \_\_\_\_\_

Household Duties: \_\_\_\_\_

Regular Activities/Hobbies: \_\_\_\_\_

Exercise: \_\_\_\_\_

Favorite ecise \_\_\_\_\_

Sleeping Position: \_\_\_\_\_

Other Activities: \_\_\_\_\_

What do you believe caused or is causing this condition? \_\_\_\_\_

Do you believe it is possible to heal 100%? If not, what percentage? \_\_\_\_\_

How long do you feel it will take? \_\_\_\_\_

The level of stress you are experiencing on a regular basis on a scale of 1 to 10

(1 being the lowest): (mild 1-3, moderate 4-7, severe 8 – 10) \_\_

## Release and Indemnification

I hereby authorize The Center for Clinical Massage to provide any and all information, copies or records to any clinic, physician, lawyer, insurance company, or workman's compensation fund as deemed necessary. A copy of this authorization shall be considered as valid as the original.

I hereby authorize any physician to release any and all information, copies of all records to The Center for Clinical Massage as deemed necessary for treatment. A copy of this authorization shall be considered as valid as the original.

I give permission that these postural photographs are strictly to be used for healthcare practitioners and will not be displayed anywhere else without my written permission.

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I also understand that this office will prepare any necessary reports to assist me in making a collection from this insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for payment.

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Signature (Guardian if under 18) \_\_\_\_\_