— ADVANCED —
MEDICAL MASSAGE
Whiplash Injury Specialists

Exceptional Treatment Massage
1112 Finnegan Way, Bellingham, WA 98225
360-527-9566 Fax 360-527-8534
www.mmWellness.com

Today's Date: ____/____/____

HEALTH INFORMATION

Patient Information

Name: Pronouns:

Address:

City: Zip:

Gender: M NB F Age: Date of Birth: / /

Home phone: Cell:

Work phone: Ext:

Email:

Preferred contact: ☐ Home ☐ Cell ☐ Work ☐ Email

Social Security #:

Occupation:

Emergency contact: Relationship:

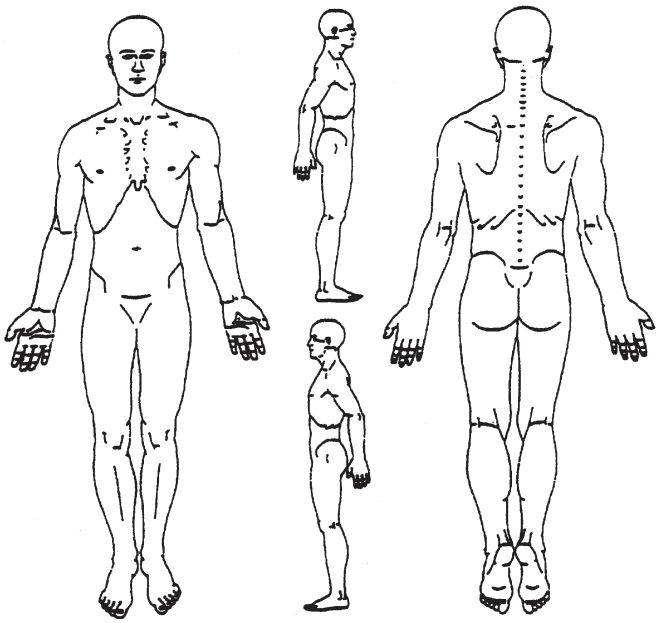
Home phone: Cell:

Referring Physician:

Permission to consult with physician/primary health care provider?
Please initial if yes: ☐ Yes _____ ☐ No ☐ Gift

How did you find out about us?
☐ Wind Sign ☐ Chair Massage/Event _____
☐ AMM Patient/Friend/Word of Mouth _____
☐ Fairhaven Guide ☐ Social Media ☐ Web Search/Website
☐ Medical Professional ☐ Other _____

Please circle areas of concern.



"The first wealth is health."
- Ralph Waldo Emerson

Patient Condition

What are your major symptoms/areas of concern?

When did your symptoms begin?

Have you had these symptoms before?

Is your condition getting progressively worse? ☐ Yes ☐ No

Is this condition: ☐ Constant ☐ Comes and Goes

How does it feel? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Aching
☐ Stiff ☐ Tingling ☐ Throbbing ☐ Swelling ☐ Other

Circle the severity of your symptoms on a scale of 0 to 10:
(no pain) **0 1 2 3 4 5 6 7 8 9 10** (severe pain)

What makes your condition better?

What makes your condition worse?

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities/movements that are painful to perform: ☐ Sitting ☐ Standing
☐ Walking ☐ Bending ☐ Lying Down ☐ Driving ☐ Reading ☐ Getting Up

Please continue on other side.

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Health History

Have you ever received a professional massage? ☐Yes ☐No

Have you ever received professional treatments for this condition?
☐Physical Therapy ☐Medication ☐Naturopath ☐Chiropractor ☐Acupuncturist ☐Orthopedic ☐Neurologist ☐Surgery

List any Medications you are taking:

Vitamins / Herbs / Minerals:

Females: Are you pregnant? ☐Yes ☐No How many weeks: Due Date:

Mark any of the following conditions you have had: (use a "✓" for any past conditions and an "X" for all current ones)

☐ Adrenal Fatigue	☐ Deafness	☐ Insomnia	☐ Sciatica
☐ Allergies	☐ Diabetes	☐ Kidney Problems	☐ Seizures
☐ Anxiety / Depression	☐ Digestion Issues	☐ Leg Pain	☐ Shingles
☐ Arm / Shoulder Pain	☐ Earache	☐ Low Back Pain	☐ Sinus Infection
☐ Arthritis	☐ Ear Ringing	☐ Low or High Blood Pressure	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Menstrual Difficulties	☐ Tendonitis
☐ Bladder Problems	☐ Headaches / Migraine	☐ Neck Pain	☐ Thyroid Issues
☐ Blood Clots	☐ Heart Disease	☐ Osteoporosis	☐ TMJ
☐ Cancer	☐ Herniated Disk	☐ Poor Circulation	☐ Vertigo / Dizziness
☐ Chronic Fatigue	☐ Hormonal Imbalances	☐ Rheumatoid Arthritis	☐ Whiplash

Have had you any: Description Date

☐ Automobile Accidents:

☐ Surgeries:

☐ Broken Bones:

☐ Falls / Head Injuries:

Lifestyle

Exercise:
☐ None
☐ Moderate
☐ Daily
☐ Heavy
What type _____
_____

Daily Routine includes:
☐ Play musical instrument
☐ Nursing or picking up small children
☐ Work at computer
☐ Driving more than 1 hr.
☐ Hold phone between shoulder & ear
Other repetitive movements?
_____

Sleep Habits:
How many hours/night? ____
Sleep on side, back, belly? circle
Use a pillow? _____
Sleeping challenges? _____
_____

Stresses:
☐ Smoking, Packs/Day _____
☐ Alcohol, Drinks/Week _____
☐ Coffee/Caffeine Drinks, Cups/Day ____
How do you manage stress in your life?
_____

Rate Stress Level (1-10) _____
Rate Energy Level (1-10) ____

Medical & Financial Agreement

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

I understand that any massage services provided by Advanced Medical Massage or by any of its associates are my sole responsibility and that I will be financially responsible for any outstanding balances for their massage services.

I understand and will comply with a 48-hour cancellation/reschedule notice of any of my appointments. I fully agree that if I do not comply with this agreement, I will be personally charged $75.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Signature: _____ Date: _____