

— 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

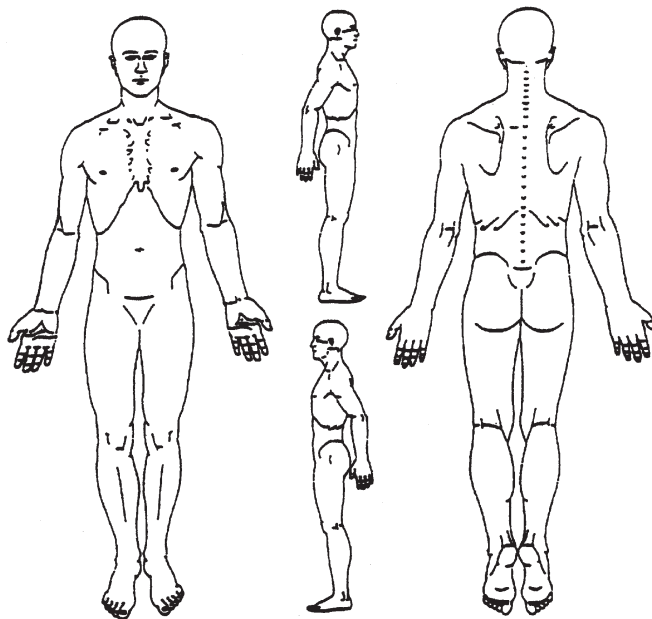
Today's Date: \_\_\_ / \_\_\_ / \_\_\_

**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 (please list them):

**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)

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

**Have you had 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

**Sleep Habits:**

How many hours/night? \_\_\_\_\_  
 Sleep on side, back, belly? circle \_\_\_\_\_  
 Use a pillow? \_\_\_\_\_  
 Sleeping challenges? \_\_\_\_\_

**Stresses:**

Smoking/Vaping: \_\_\_\_\_  
 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 consent to massage therapy treatment with a licensed massage therapist.

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 \$95.

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: \_\_\_\_\_