CHRISTINA M. MITCHELL, LMT, LLC - THERAPEUTIC MASSAGE MA49769 MM22673

DATE :_____ REFERRED BY :_____

NAME: _____ DOB: _____AGE:_____ MARITAL STATUS: _____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

PHONE CELL: _____ PHONE HOME:_____PHONE OTHER:_____

PROFESSION: _____EMAIL:_____

EMERGENCY CONTACT NAME:_____EMERGENCY PHONE:_____

PHYSICIAN: _____ PHONE: _____

REASON FOR VISIT: _____

AREAS OF PAIN OR DISCOMFORT-SCALE 1/10:_____
WHAT ARE YOUR EXPECTATIONS? _____
MEDICATIONS: _____

SYMPTOMS AND CONDITIONS

Abdominal Pain	High Blood Pressure
Abdominal Aortic Aneurysm	(Controlled with Medication)
Allergies	HIV/AIDS
Arthritis	Hysterectomy
Asthma	Joint Replacement
Auto Accident	Knee Surgery
Auto Immune Illness	Laminectomy
Back Pain	Ligament Tears
Blood Clots	Lymph Node Removal
Broken Bones	Low Blood Pressure
Bursitis	Neck Injury or Whiplash
Cancer	Nervousness
Carpel Tunnel	Osteoporosis
Chest Pain	Pregnancy
Circulation Problems	Respiratory Illness
Colitis	Sciatica
Congestive Heart Failure	Scoliosis
Constipation	Shortness of Breath
Coccyx Injury	Sinus Congestion
Contagious Diseases	Skin Disorders
Diabetes Insulin	Spinal Injury
Diabetes Non-Insulin	Sprains, Falls or Stitches
Difficulty Breathing	Stroke
Dizziness or Vertigo	Surgery
DVT	
Edema	Swelling or Edema
Epilepsy or Seizures	Tendonitis
Fainting	Thyroid Problem
Fibromyalgia Syndrome	TMJ
Headaches or Migraines	Tuberculosis
Heart Problems	Ulcer
Herniated Disc	Varicose Veins
Hormonal Problems	Other: _____ Allergies:_____

PERMISSION TO TREAT –FEE FOR SERVICE ONLY. I DO NOT PARTICIPATE WITH MEDICARE, MEDICAID OR COMMERCIAL INSURANCE COMPANIES.

SIGNATURE: _____ DATE: _____

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