BackFit Health + Spine

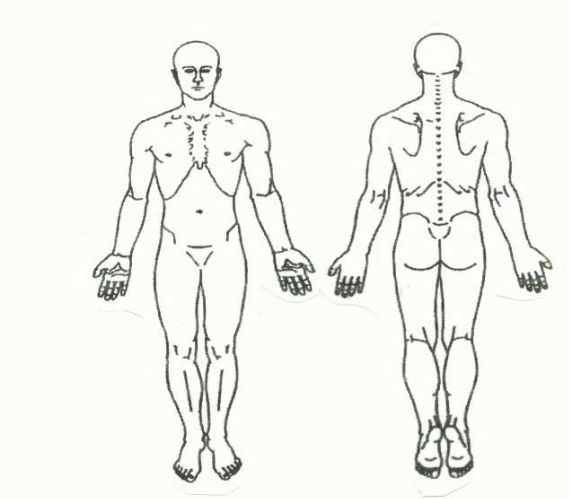
MASSAGE DEPARTMENT

Patient Application

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone # _____ Cell Phone # _____
Occupation _____ Date of Birth _____
E-mail Address _____
How did you hear about us? _____

Chief complaint or reason for massage _____
Have you had a massage before? **Yes or No**
If so when was it? _____ What type was it? _____

Do you have any injuries/ surgeries that we need to know about?
_____
Have you been in a car accident or work related accident in the last two years?
_____
Do you ever experience any pain, numbness or tingling? **Yes or No**
If so please mark a **"X "**on the picture to indicate



What type of pain is it? (please check all that apply)
___Sharp ___Dull ___ Throbbing ___Numbness ___ Aching ___ Shooting ___ Burning ___ Tingling ___ Stiffness ___Swelling ___Other _____
How often do you have this pain?_____
Rate the pain on a scale of 1(least) to 10 (severe) _____
Does it affect your ___ Work ___ Sleep ___ Recreation ___ Daily Routine___ Sitting ___ Standing ___ Walking ___ Bending ___ Lying Down ___ Other _____

(Please circle the following that apply to you)

Exercise	**Work Activity**
None	Sitting
Moderate	Standing
Daily	Light Labor
Heavy	Heavy Labor

Patient Signature_____ Today's Date _____