

Confidential New Patient Form

Name: _____ Phone: Home - _____

Address _____ Work - _____

City/Prov/Postal Code: _____ Marital Status _____

E-mail address: _____

Date of Birth: _____ Referred by _____

or

Occupation: _____ Rotation: Yellow Pgs? ____ or Other? ____

Primary Health Care Provider: _____ Phone: _____

Permission to consult with health care provider: Yes _____ No _____

***** It is the policy of Temple Crossing Therapeutic Massage that payment is made at the time of service. Receipts are provided for the patient to arrange reimbursement *****

Past History (include description & date)

Surgeries/operations: _____

Accidents/falls: _____

List current medications (including aspirin, ibuprofen, antihistamines, birth control, etc.)

Please check the appropriate box for any of the following conditions you currently have.

Please underline any of the following conditions that you have had in the past.

Musculoskeletal

- Bone or joint disease
- Tendonitis
- Bursitis
- Broken/fractures bones
- Arthritis
- Sprain/strains
- Low back/hip/leg pain
- Neck/shoulder/arm pain
- Headaches/head injuries
- Spasms/cramps
- Jaw pain/TMJ
- Flat feet/high arches

Other: _____

Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Asthma
- Allergies
- Ear aches

Nervous System

- Numbness/tingling
- Chronic pain
- Herpes/shingles
- Fatigue

Other: _____

Digestive

- Constipation
- Diarrhea
- Gas/bloating
- Irritable bowel syndrome

Other: _____

Skin

- Dryness
- Bruise easily
- Rashes
- Athletes foot
- Warts

Other: _____

Circulatory

- Heart conditions
- Varicose veins
- Blood clots
- High blood pressure
- Low blood pressure
- Lymphedema

Other: _____

Gesto-urinary

- Pregnant
- How many mos? _____
- PMS
- Menopause
- Frequent urination
- Kidney infection
- Painful urination
- Prostrate trouble

Other: _____

Other

- Cancers/tumors
- Diabetes
- Mental health conditions
- Poor nutrition
- Drug/alcohol consumption
- Caffeine

Other: _____

Infectious Diseases:

Names: _____