Don Wheeler LMT.
Joleen Kolk LMT
Neuromuscular Therapy

Corrective Massage Therapy

Patient Number:______
Date of First Visit:_______

Last Name: ______________________First Name:___________________ MI:_________
Address:____
City:____________________________________ State:_______ Zip Code:___________
Email address: ____
Phone: H (____) ______-______ W (____) ______-______ C (___) _____-_____
Other(____)______-______ If From Out of town, Local Phone: (____)_____-____
Social Security Number:______-____-_____ DOB:________ Age:______

Sex: Male___ **Female_X_** Height:___' ___" Weight_______ lbs
Marital Status: S____M____D____W_____
Place of Employment:____
Address:____
Spouses Name:______________________ Spouses
Employment:____
Phone: (____) _____-____ Other(___)___-____

Who Referred You?____

How Did You Hear about Us?____

Habits	Heavy	Moderate	Light	None
Tobacco				
Weekly sugar				
Alcohol				
Coffee				
Tea				
Exercise				

Current Condition:

What Has brought you here today?

____

List up to five things in order of Priority, that you would like corrected:

(1)________________(2)________________ (3) _______________ (4) ______________ (5)______________

Past History:

Have You had similar problems before? Yes /No If Yes, When?

____

What caused the episodes?

____

What do you think relieved them?

____

Did they disable you? Yes / No Prevent you from working? Yes / No

Hospitalize you? Yes / No

What was previous diagnosis?____

What were the treatments?____

Did they help? Yes / No

Name of Physician:________________________________ Phone(____)_____-_______

Have you ever had any operations? Yes / No

If Yes, describe briefly & give year:____

Any Broken Bones? Yes / No Which Bones?______________________________Date________

Been in an Accident? Yes / No Date:______

Describe:____

Constipation? Yes / No How many bowel movements per day?______ If Yes,

What have you done to relieve it?

____

To the best of your knowledge, do you have any contagious diseases, *i.e.* HIV,

Harpies, Mono,? Yes / No

If Yes, Which, & What Treatment are you receiving?_______________________________________

Do you have any form of cancer? Yes / No If yes, where in the body?_________________________

List any medications you are currently taking:____

Has anyone ever told you that you have an anatomically short leg? Yes /

No Fallen Arch Yes / No

Do you wear heal lifts? Yes / No Sole lifts? Yes / No Arch Supports? Yes/ No

Do you use a foam Pillow? Yes / No Feather? Yes / No Orthopedic? Yes /No

Age of mattress:___________ Is your mattress Comfortable? Yes / No

Do you bruise easily? (Black and Blue Marks)__________________________________

Is there anything else you can think of that might help me treat you?

____

How would it effect your life if you no longer had the condition that brought

you in today?

____

Would you give me permission to send you an occasional E-mail to check in

on you &/or to let you know about any specials we might be offering?**Yes** / **No**

Do You Have Difficulty With Any of the Following:

___Headaches
___Shooting Head Pain
___Sinus Trouble
___Neuritis in Shoulder
___Pins & Needles inArms/Hands
___Loss of Taste
___Tightness in Throat
___Inflamed Throat
___Heart Pain
___Heart Palpitations
___Heart Attacks
___High Blood Pressure
___Low Blood Pressure
___Anemia
___Rheumatic Fever
___Stomach Trouble
___Ulcers
___Nerves or Nervousness
___Inner Tension
___Irritability
___Phlebitis
___Fainting
___Ringing in Ears
___Light Bothers Eyes

___Muscle Spasms
___Grating in Neck
___Tightness of Shoulder Muscle
___Indigestion
___Intestinal Gas
___Cold Hands
___Chest Pain
___Shortness of Breath
___Tuberculosis
___Cancer
___Sleeping Problems
___Painful Joints
___Swollen Joints
___Arthritis
___Slipped Disc
___Pinched Back Nerve
___Pins & Needles in Legs
___Swollen Ankles
___Cold Feet
___Pain in Legs & Feet
___Skin Allergies
___Allergies to Lotion
___Loss of Balance

___Allergies to Oil
___Allergies to Fragrance
___Gall Bladder Trouble
___Thrombosis
___Cold Sweat
___Liver Trouble
___Diabetes
___Loss of Smell
___Hay Fever
___Asthma
___Constipation
___Kidney Trouble
___Bladder Trouble
___Thyroid Trouble
___Face Flushing
___Twitching of Face
___Loss of Memory
___Fatigue
___Depression
___Head Feels Too Heavy
___Dizziness
___Wear Glasses
___Bruise Easily

Female Only

___ Are You Pregnant?
___Very Easily Fatigued
___Painful Menstruation Cramps
___Painful Breasts
___Melancholia of Long Standing

___Premenstrual Tension or Depression
___Menstruation Excessive or Prolonged
___Menopausal Hot Flashes, Etc.
___IUD or Diaphragm

CORRECTIVE MASSAGE THERAPY - Don Wheeler, L.M.T .

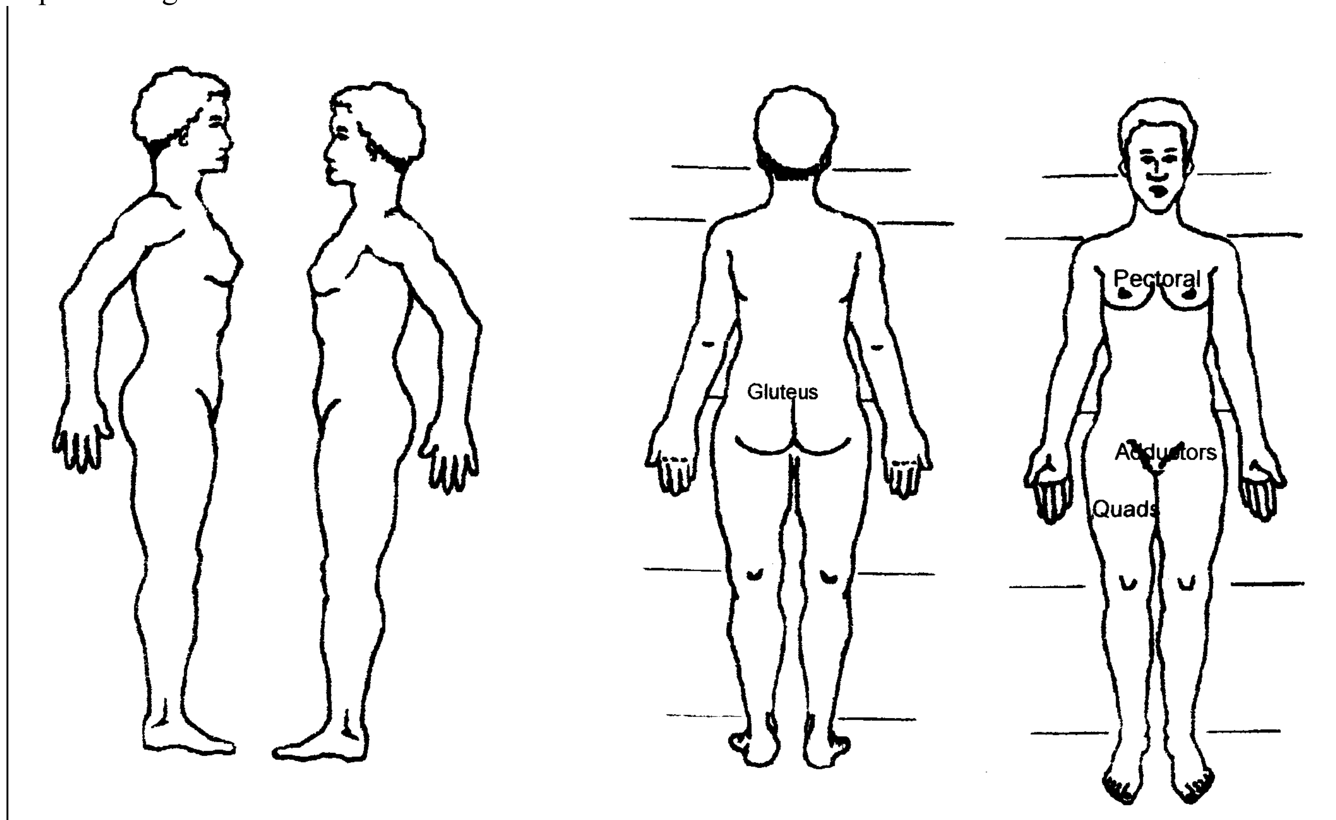
The picture below indicates what areas may be treated during your session. Please indicate areas you feel pain.

In Neuromuscular work, it is important that all ischemic muscles be treated from origin to insertion. This may require treating areas such as the pectoral, gluteus, quads, adductors, and so forth. I make every effort to keep you informed as to where I'll be treating and why. However, if at any time you feel uncomfortable with any procedure or area being treated, please do not hesitate to tell me, so I can stop, until you feel comfortable with the work.

Consent to work areas mentioned above: (Please circle one) **YES / NO**

Normally, we will either ask you to wear an exam gown or use a drape. Either way, you are covered on any area that we're not working on.

Your therapy session will consist of different modalities such as Neuromuscular, Swedish & possibly Aqua massage.



I hereby certify that the information on this form is true and accurate to the best of my knowledge. I understand that massage therapy is not a substitute for medical examination. I agree to pay the therapist for missed appointments. I am responsible for keeping the therapist updated on any changes in my health. I hereby release him from any claims or liability. I understand that if at any time I become uncomfortable for any reason, I may ask that the session be ended.

____

Patient Signature

Please Note

WHEN YOU MAKE AN APPOINTMENT WITH US , WE START WORKING FOR YOU.

WE RESERVE THAT TIME AND DAY ESPECIALLY FOR YOU , WHICH IN TURN MAKES THAT TIME UNAVAILABLE FOR
OTHERS WHO MAY NEED IT.

WE START WORKING FOR YOU IN ADVANCE BY PULLING YOUR FILES TO REVIEW YOUR SPECIFIC TREATMENTS, X-RAYS,
MEDS, HOMEWORK, ETC.

SO BY THE TIME YOU ACTUALLY COME IN FOR YOUR APPOINTMENT , WE HAVE DEVOTED OUR TIME , ENERGIES AND
OUR RESOURCES INTO YOUR APPOINTMENT.

If we Do Not Receive 24 hr. Notice of your cancellation
You Will be Charged for the Appointment

IF YOU ABSOLUTELY MUST CANCEL OR RESCHEDULE YOUR APPOINTMENT,
KINDLY GIVE US AS MUCH NOTICE AS POSSIBLE.

We hope You understand That without 24 hr notice of your cancellation we will have to Charge You for the appointment.

~Thank you for Your Consideration~

I have read this form and agree to the terms therein.

Signature: ________________________ Print Name: __________________________________