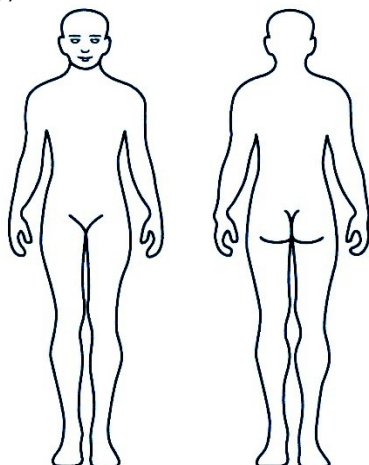


Artful Touch PATIENT REGISTRATION DATE _____

Your Basic Information	How you're feeling																								
<p>Name _____</p> <p>Birth date: _____ Age: _____</p> <p>Sex (circle): M F</p> <p>Cell Phone: _____</p> <p>Home Phone: _____</p> <p>Address: _____ _____, _____</p> <p>Email: _____</p> <p>Employer name _____</p> <p>Employment type: _____</p> <p>Seeking treatment due to a work accident? YES NO</p> <p>Want receipts for insurance billing? YES NO</p> <p>Whom may we thank for referring you? _____</p>	<p>Are you here to address a specific problem? _____</p> <p>When did your main symptoms appear? _____</p> <p>Is the condition worsening? YES NO UNKNOWN</p> <p>Type of Pain (circle all that apply):</p> <table style="width: 100%; border: none;"> <tr> <td>Sharp/Dull</td> <td>Throbbing</td> <td>Numbness</td> <td>Aching</td> </tr> <tr> <td>Shooting</td> <td>Burning</td> <td>Tingling</td> <td>Stiffness</td> </tr> <tr> <td>Swelling</td> <td>Cramping</td> <td>Pins/Needles</td> <td>Other</td> </tr> </table> <p>How often? _____</p> <p>Consistency (circle): Constant Intermittent</p> <p>Severity (today): 1 2 3 4 5 6 7 8 9 10</p> <div style="text-align: center; margin: 10px 0;">  </div> <p>Mark an X on the picture where you'd like work addressed</p>	Sharp/Dull	Throbbing	Numbness	Aching	Shooting	Burning	Tingling	Stiffness	Swelling	Cramping	Pins/Needles	Other												
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Shooting	Burning	Tingling	Stiffness																						
Swelling	Cramping	Pins/Needles	Other																						
<p>Your Massage Experience</p> <p>How often/Type _____</p> <p>Likes _____</p> <p>What are you hoping to get out of your massage today? _____</p>																									
<p>Injuries/Surgeries you've had. These are important and may shed light on current postural issues, even if you don't think they were that bad at the time. Please include fender benders and the like, and injuries in childhood.</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 65%;">Description</th> <th style="width: 20%;">Date</th> </tr> </thead> <tbody> <tr> <td>MVA's</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Sprains/Strains</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Head Injury</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Broken Bones</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Dislocations</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Surgeries</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Other</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>			Description	Date	MVA's	_____	_____	Sprains/Strains	_____	_____	Head Injury	_____	_____	Broken Bones	_____	_____	Dislocations	_____	_____	Surgeries	_____	_____	Other	_____	_____
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Artful Touch PATIENT REGISTRATION (Cont'd)

Your Disease History

Do you have, or have you had in the past, any of the following diseases (please circle):

Cancer, Heart disease, High Blood Pressure, Skin Conditions/Rashes, Diabetes, HIV/AIDS, Herpes, Headaches, Migraines, Kidney/Liver Disease, IBS, Celiac, Seasonal Allergies, Psychiatric conditions.

Other/Details (Date of Onset, Frequency, Diagnosis, Tx/Rx). Please also list any conditions which are chronic or recurring, such as frequent infections or other dysfunction: _____

Are you currently on any medications, including over the counter pain killers or cold medicine? _____

Any family History of significant disease? _____

Are you Pregnant? YES NO UNKNOWN Congrats! When is your due date? _____

Your Nutrition and Overall Health

How do you tend to eat? (A huge meal a day/Lots of small meals) _____

Favorite foods? _____

When you crave junk, do you go for sweets, or salt/fat? _____

Height _____ Weight _____ Allergies _____

Vitamins/Supplements _____

Do you fall asleep easily? _____ Stay asleep through the night? _____

How many hours of sleep on average? _____ Do you wake feeling rested? _____

How's your water intake? _____ Do you carry a bottle? _____

Daily Exercise	Work Activity	Fun Habits
Type: _____ <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Insanity!!	_____ <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light labor <input type="checkbox"/> Heavy labor	_____ <input type="checkbox"/> Smoking Packs/day _____ <input type="checkbox"/> Alcohol Drinks/week _____ <input type="checkbox"/> Caffeine Cups/day _____ <input type="checkbox"/> High Stress Reason _____