124 East Augusta Ave, Suite 300
Spokane, WA 99206 509.325.4874

First Time Visit Form

Sports Massage

Date: ______/______/______/
First Name: ______________________________Middle Initial: ______ Last Name: _______________________
Address: _____________________________________ City:___________ State: _____ Zip Code:___________
Home Phone: (___) ______________ Cell Phone: (____) ________________ Email: ______________________

Insurance Information
Name of Employer: ____
Name of Health Insurance Provider: __________________________ Group No: _______________________
Member Name on Card: ______________________________ Member ID No: ________________________
Your Co-Pay Amount: $___________ Number of Allowable Visits Per Year: _________________________

Prescription Referral
Name of Your Physician: __________________________________ Telephone: (____) __________________
Address: _____________________________________ City:___________ State: _____ Zip Code:___________

☐ I am not covered for massage therapy through insurance

<u>Confidential Information</u>
Date of Birth: ______/______/______ Emergency Contact: ____
Telephone: (____) __________________________ Relationship: ______________________________________

Is this your first professional massage? ☐Yes ☐No

What sport/sports are you engaged in: ____
____

Do you engage in your sport/sports on a daily basis? ☐ Yes ☐ No If no, how many time a week?
____

Are you seeking massage therapy for a recent injury or for a re-occuring symptom or pain?
☐ Recent injury ☐ Re-occuring symptom

If an injury, how did your injury occur?
____
____
____
____

If a re-occuring symptom or pain, please describe.
____
____
____
____

What conditions are you currently experiencing?

BACK

- ☐ Pain ☐ Middle ☐ Lower
- ☐ Stiffness ☐ Middle ☐ Lower
- ☐ Muscle spasms ☐ Middle ☐ Lower
- ☐ Pain between shoulder blades
- ☐ Pain from front to back
- ☐ Low back weakness
- ☐ Pinched nerve in low back

HANDS AND ARMS (Right, Left, Both)

- ☐ Pain in upper arm ☐ R ☐ L ☐ Both
- ☐ Pain in elbow ☐ R ☐ L ☐ Both
- ☐ Pain in forearm ☐ R ☐ L ☐ Both
- ☐ Pain in hand ☐ R ☐ L ☐ Both
- ☐ Pain in fingers ☐ R ☐ L ☐ Both
- ☐ Pins & needles in arm ☐ R ☐ L ☐ Both
- ☐ Pins & needles in fingers ☐ R ☐ L ☐ Both
- ☐ Numbness in arm ☐ R ☐ L ☐ Both
- ☐ Numbness in fingers ☐ R ☐ L ☐ Both
- ☐ Weakness of arm ☐ R ☐ L ☐ Both
- ☐ Weakness of hand ☐ R ☐ L ☐ Both
- ☐ Cold hands

NECK

- ☐ General pain
- ☐ Stiffness
- ☐ Weakness
- ☐ Pinched Nerve
- ☐ Neck feels out of place
- ☐ Muscle spasms
- ☐ Grinding/popping sounds

HIPS, LEGS & FEET (Right, Left, Both)

- ☐ Pain in buttocks ☐ R ☐ L ☐ Both
- ☐ Pain in hip joint ☐ R ☐ L ☐ Both
- ☐ Pain down leg ☐ R ☐ L ☐ Both
- ☐ Pain in knee ☐ R ☐ L ☐ Both
- ☐ Pain in ankle ☐ R ☐ L ☐ Both
- ☐ Pain in foot ☐ R ☐ L ☐ Both
- ☐ Weakness of leg ☐ R ☐ L ☐ Both
- ☐ Weakness of knee ☐ R ☐ L ☐ Both
- ☐ Leg cramps ☐ R ☐ L ☐ Both

Other Symptoms

____

____

____

Is the pain constant or does it come and go? ☐ Comes and goes ☐ Constant

Activities that are painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying Down
☐ Other
____

Describe the pain: ☐ Dull ☐ Sharp ☐ Achy ☐ Burning ☐ Throbbing ☐ Numb ☐ Tingling ☐ Other
____

At the moment the pain is: ☐ I have no pain ☐ Very Mild ☐ Moderate ☐ Fairly Severe
☐ Very Severe ☐ Unbearable

I am experiencing headaches: ☐ Rarely ☐ Most Of The Time

Describe what activities cause the pain and/or make it worse:
____
____

Does you condition interfere with your normal daily function? ☐ Yes ☐ No If yes, explain:
____
____
____

Please √ any of the following conditions that you are currently experiencing:
☐ Arthritis ☐ Bursitis ☐ Carpal Tunnel ☐ Cramps ☐ Fibromyalgia ☐ Plantar Fascitis ☐ Sciatica
☐ Tendonitis ☐ TMJ

Are you experiencing any of the following? ☐ Hernia ☐ Recent Bone Fracture ☐ Tumor

PLEASE READ AND SIGN

I ________________________________ (please print) acknowledge that the above information is complete and accurate to the best of my knowledge. I agree to the release of information, if necessary, for medical and/or insurance purposes.

Signature: ______________________________________

Name: ___________________________________ Date:_____________________________

Identify current symptomatic areas in your body by using the appropriate symbol for the Condition and/or conditions you are currently experiencing.

O Circle any areas that are painful

X Place an X over areas where you are experiencing any stiffness

≈ Draw squiggly lines in areas where you are experiencing tingling and/or numbness

↙ Note any scars, bruising or open wounds

Additional Comments:

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