## Mollie M. Ferreira, LMT MAT 5722 dba Essential Massage Therapy

# REGISTRATION FORM

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| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| Client INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Client’s last name: | | | | | | | | | | | | | | | | First: | | | | | | | | | | Middle: | | | | | ❑ Mr.  ❑ Mrs. | | | | ❑ Miss  ❑ Ms. | | | | | Marital status (circle one) | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | S / Mar / Div. / Sep / W | | | | | | | | | |
| Is this your 1st massage? | | | | | | When was your last Massage? | | | | | | | | | | | | | | | | | Who worked on you? | | | | | | | | | | | | | | Birth date: | | | | | | Age: | | Gender | | | | |
| ❑ Yes | | | ❑ No | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | / / | | | | | |  | | ❑ M | | | ❑ F | |
| Mailing address: | | | | | | | | | | | | | | | | | | | | | | | | | | | City: | | | | | | | | | | | | | Home phone no.: | | | | | | | | | |
| Physical address  E-mail | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | Cell phone no. | | | | | | | | | |
|  | | | Preferred method of communication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | | | ZIP Code: | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| Occupation: | | | Employer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | |
| Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | ❑ Dr. | | |  | | | | | | | | | | | | |  | | | | | |  | | |
| ❑ Family | | ❑ Friend | | | | | ❑Online | | | | | | | | | | | | | | ❑ Yellow Pages | | | | | | | | | | | | ❑ Other | | | | |  | | | | | | | | | | | |
| Other family members seen here: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| about you | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are there any areas you don’t want me to work on? | | | | | | | |  | What is your chief complaint or area you want to improve? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | What is your goal for this visit? | | | | | | | | | | | |
|  | | | | | | | |  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| When did you first notice chief complaint? | | | | | | | |  | | | | | |  | | | What brought it on? | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| What aggravates it? | | | | | Is it getting worse? | | | | | | | | | Does it interfere with | | | | | | | | | | | | | | | | | | | | | | | | | | What have you done to get relief? | | | | | | | | | |
|  | | | | |  | | | | | | | | | Work? Sleep? Daily routine? | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Has there been a medical diagnosis? | | | | | | | | | | | |  | | | | | | |  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you under medical treatment for any condition? | | | | | | | | | | What? | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |  | | | | |  | | | | | |
| Who is treating you? | | | |  | | | | | | | | | | |  | | | | | | | Do I have permission to discuss treatment with them? | | | | | | | | | | | | | | | | |  | | |  | | | | | | | |
| List medications and supplements you’re taking. | | | | | | | | | | | | |  | | | | |  | | | | | | |  | | | | |  | | | | | | | | | | | | |  | | | | | | |
| Describe your  exercise activities and frequency: | | | | | | | | | | | | | | | | | | | List accidents / operations | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative | | | | | | | | | | | | | | | | | | | | | | | | Relationship to patient: | | | | | | | | | | | | | | | | | | | Home phone no.: | | | Work phone no.: | | | | |
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**Health History**

Please indicate the conditions that apply to you, past and present.

Musculo-Skeletal Skin Reproductive System

Headaches rashes pregnancy past / present

Joint stiffness / swelling allergies PMS

Spasms / cramps athletes foot menopause

Broken bones warts Pelvic inflammatory disease

Strains / sprains moles endometriosis

Back pain; upper / lower acne hysterectomy

Hip pain nail fungus fertility concerns

Shoulder / neck pain other prostate problems

Elbow / wrist / hand pain

Problems walking Digestive Other

Chest / rib / abdominal pain nervous stomach forgetfulness

Jaw / TMJ pain indigestion confusion

Tendonitis constipation depression

Bursitis gas / bloating difficulty concentrating

Arthritis diarrhea hearing impaired

Osteoporosis diverticulitis visually impaired

Scoliosis irritable bowel syndrome bladder infection

Bone or joint disease crohn’s disease infectious disease

Eating disorder

Circulatory & Respiratory Nervous System diabetes

High / low blood pressure numbness / tingling fibromyalgia

Blood clots / DVT twitching of face post-polio syndrome

Varicose veins fatigue cancer

Lymphedema chronic pain Alzheimer’s

Asthma / emphysema sleep disorders vertigo / motion sickness

Sinus problems / allergies ulcers Aids / ARC

Heart condition paralysis congenital or acquired disability

Stroke herpes / shingles autoimmune disorder

Swollen ankles cerebral palsy Muscular dystrophy

Cold sweats epilepsy

Cold feet or hands chronic fatigue syndrome CRS

Fainting / dizziness multiple sclerosis

COPD Parkinson’s

The above information is true to the best of my knowledge. I will inform you of any change in my health status. I understand that there will be no sexual interaction between practitioner and client, I understand the practitioner has the right to terminate the massage at their discretion and receive payment in full. I authorize my insurance benefits be paid directly to the practitioner. I understand that I am financially responsible for all charges. I also authorize Mollie M. Ferreira, LMT MAT 5722 dba Essential Massage Therapy or insurance company to release any information required to process my claims.

Client/Guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_