

Date _____ Phone(____) ____-____ (H)
 Name _____ Birth date _____ (____) ____-____ (W)
 Address _____ (____) ____-____ (cell)
 _____ Zip Code _____ Email _____
 Occupation _____
 How did you hear about us? _____ Marital Status _____

Accidents (what kind?)	Injury	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgery	Date
_____	_____
_____	_____

Medical Conditions

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> allergies | <input type="checkbox"/> endometriosis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> migraine |
| <input type="checkbox"/> anemia | <input type="checkbox"/> epilepsy | <input type="checkbox"/> hypertension | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> hyperthyroid | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> asthma | <input type="checkbox"/> gout | <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> sinusitis |
| <input type="checkbox"/> cancer | <input type="checkbox"/> heart disease | <input type="checkbox"/> hypothyroid | <input type="checkbox"/> stroke |
| <input type="checkbox"/> chronic infection | <input type="checkbox"/> herpes | <input type="checkbox"/> indigestion | <input type="checkbox"/> tinnitus |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hiatal hernia | <input type="checkbox"/> irritable bowel | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> diabetes | | | |

Other conditions: _____

Do you have any of the following symptoms?

- | | | |
|---|--|---|
| <input type="checkbox"/> intolerance of cold | <input type="checkbox"/> feeling of anxiety | <input type="checkbox"/> stuffy feeling in ears or
loss of hearing |
| <input type="checkbox"/> intolerance of heat | <input type="checkbox"/> dry, rough skin | <input type="checkbox"/> blurred vision |
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> rapid heart rate | <input type="checkbox"/> unexplained pain in teeth |
| <input type="checkbox"/> depression | <input type="checkbox"/> nausea | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> increase in pain with onset
cold, rainy weather | <input type="checkbox"/> headaches (how often? ____) | <input type="checkbox"/> numbness (where? ____) |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> dizziness | <input type="checkbox"/> unusual or sudden weakness
(where? _____) |
| <input type="checkbox"/> sweating | <input type="checkbox"/> veering to one side while
walking or driving | |
| <input type="checkbox"/> trembling or shaking | <input type="checkbox"/> unexplained throat pain | |

Describe any other disturbing symptoms (non-pain):

For women: Are you pregnant? _____ Are your menstrual periods normal? _____

Do you have PMS? _____ If yes, is it mild? _____ moderate? _____ severe? _____

Referring Physician _____ Regular Physician _____

Person to call in emergency _____ Phone (____) ____-____ Relationship _____

Alexandria Myotherapy, Inc.
333 N. Fairfax St. Suite 303
Alexandria, VA 22314

Present complaint: _____

What is the medical diagnosis? _____

How long have you had this complaint? _____

Have you had a similar complaint before? _____ When? _____

Did this problem begin: _____ gradually? _____ suddenly? _____

What do you believe caused your problem? _____

Is your problem: _____ constant? _____ intermittent? How often? _____

Does the intensity of your problem vary? _____ Explain: _____

What helps your condition? _____

What aggravates your condition? _____

Current Medications	Purpose	Effectiveness
_____	_____	_____
_____	_____	_____
_____	_____	_____

Which of the following do you use regularly?

___ vitamin/mineral supplements, specify _____

___ tobacco how much? _____ ___ alcohol how much? _____

___ caffeine how much? _____ ___ sugar how much? _____

Therapies used (including massage) Effectiveness

_____	_____
_____	_____
_____	_____

Does your problem interfere with: ___ sleep? ___ work? ___ recreation?

Sleep is: ___ excellent ___ good ___ fair ___ poor

Is your mattress firm? _____ How many hours do you sit? _____ stand? _____

Drive? _____ If you work at a computer, for how many hours? _____

If you cradle the telephone between ear and shoulder, for how many hours? _____

What are your main activities outside of work? _____

Do you exercise regularly? _____ Describe: _____

Do you feel that stress contributes to your problem? ___

If so, is the stress ___ physical? ___ emotional?

Do you clench your teeth? ___ Do you grind your teeth? ___ Have you ever been diagnosed as having a problem with your jaw? ___ If so, do you wear an appliance? ___

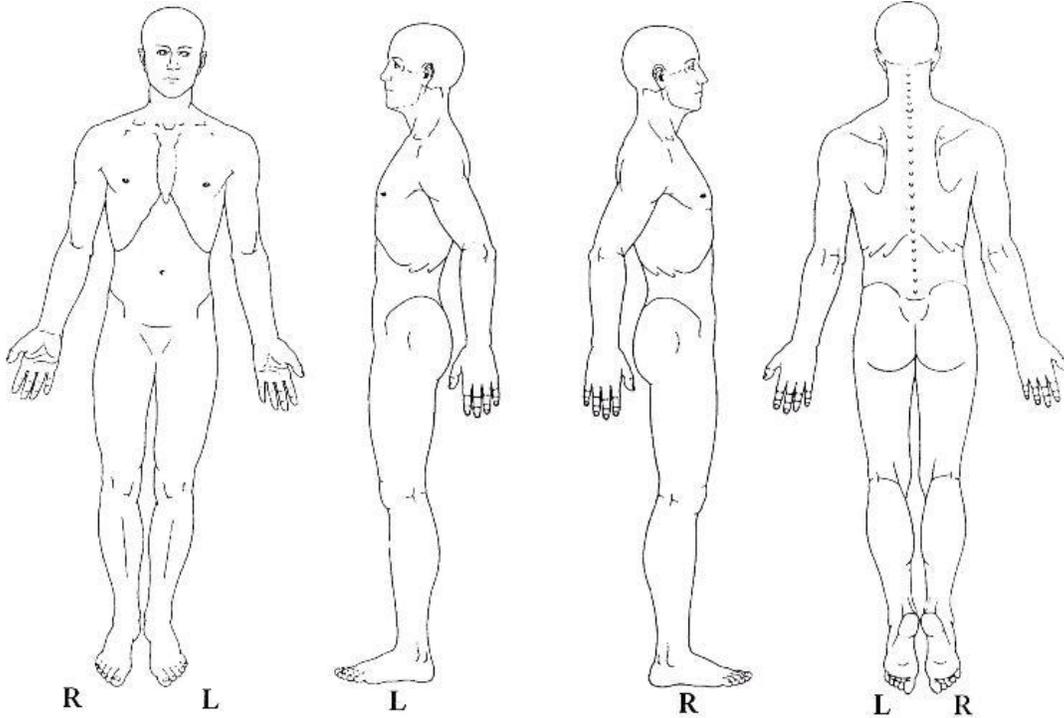
Are you wearing: ___ heel lifts? ___ orthotics?

Additional comments:

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Alexandria, VA 22314
(703) 548-2270

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Name _____
Date ____/____/____



Please draw in the areas of pain or discomfort or region to focus on today in the above diagrams. Which area is most bothersome? Rank the area of pain, beginning with the most bothersome.

1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____ 8. _____

-----For Office Use Only-----

Jaw Opening: _____ Cervical Flexion _____
Rotation: Right _____ Left _____
Lateral Flexion: Right _____ Left _____
Hyperextension: _____ Shoulder ab. Right _____ Left _____
Hip Height: _____

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CLIENT AGREEMENT

I am aware that when I make an appointment, the scheduled time is reserved for me, and should I cancel with less than 24 hours' notice, I am responsible for payment in full. I understand, too, that if I am late for an appointment, the therapist may not be able to give me a full session, though I am responsible for the full charge.

I understand that massage is not a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any physical or mental ailment of which I am aware. I understand that the massage therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. I also understand that the employees of Alexandria Myotherapy, Inc. have access to my records. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist informed of any changes in my medical condition and understand that there shall be no liability on the therapist's part should I neglect to do so.

I agree to let the therapist know whether any procedure is causing me discomfort, whether from pressure, heat, or any other cause. I understand that failure to do so may cause me harm, and there shall be no liability on the therapist's part if I fail to communicate my discomfort.

I have read and understand the policies and fee schedule and testify that the information I have provided is true.

Signature

Date

I agree to pay for any appointments I fail to keep without giving 24 hours notice.

Signature

Date

Please keep this in your glove compartment and place it in one of your windows when you park in the garage, which is permitted only on weekends or after 5:30 weekdays.

Please note: On occasion there is a parking company that takes over the garage on weekends, and then you will need the visitor pass to avoid paying a parking fee.

----- tear here -----

V I S I T O R

to

Alexandria Myotherapy, Inc.
Suite 303 703-548-2270

Valid only weekdays after 5:30 p.m.

and on weekends.