FOLSOM PHYSICAL THERAPY
and Training Center

(916) 355-8500
115 Natoma Street
Folsom, CA 95630
fpt@folsomphysicaltherapy.com

HEALTH AND PERFORMANCE MASSAGE

Name: _________________________________ Phone: ____________________ Date: ______________

Address: ____

Emergency Contact: ____

Have you had previous massage therapy / body work? *Yes / No*

Are you involved in a regular exercise program? *Yes / No*

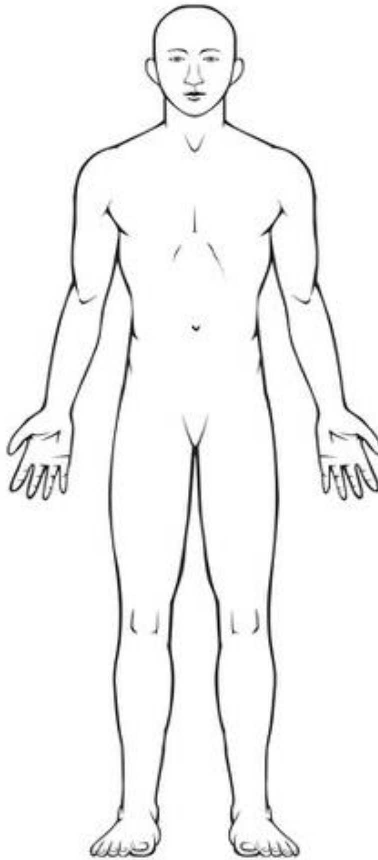
What type? _________________________________

How often? _________________________________

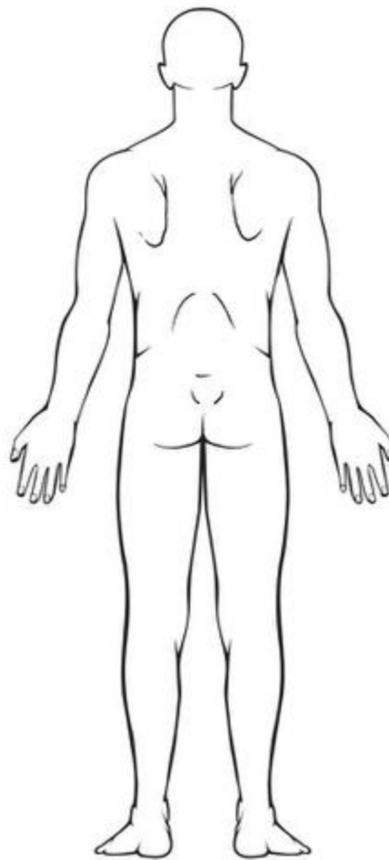
What are your TOP 3 areas of focus:

1. _________________________________
2. _________________________________
3. _________________________________

Mark all areas of focus:



FRONT



BACK

RIGHT

LEFT

COMMENTS:

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HEALTH HISTORY

Yes	No	
○	○	Osteoporosis
○	○	Diabetes
○	○	Hypertension (High Blood Pressure)
○	○	Heart Disease
○	○	Cancer or Tumors
○	○	Lung Problems
○	○	Stomach Problems
○	○	Kidney or Liver Problems
○	○	Arthritis or other Joint Problems
○	○	Seizures or Nervous Disorders
○	○	Allergies
○	○	Dermatitis or any Skin Problems
○	○	Eye Problems
○	○	Hernias
○	○	Unusual/ Frequent Headaches
○	○	**Are there any other health problems not mentioned above? If so please describe:**
○	○	**Do you have any family history of any of the above problems? If so, please describe:**
○	○	Are you pregnant?
○	○	Do you have any implants? (i.e. joint replacements or pacemakers)?
○	○	Are you awakened at night?
○	○	Do you ever have uncontrolled leakage of urine, gas, or feces?
○	○	Have you ever taken any medications for longer than a few weeks?
○	○	Have you ever taken any steroid medications such as cortisone?
○	○	Are you currently taking any medications?
○	○	Have you ever been hospitalized?
○	○	Have you ever had surgery?
○	○	Have you ever been placed in a splint, cast, ace wrap or sling?
○	○	Have you ever had to use crutches, canes, a walker, or wheelchair?
○	○	Do you use any shoe lifts, braces, corsets, or supports?
○	○	Are you currently treated by any other doctor, therapist, chiropractor, masseuse, podiatrist, etc.

Do you consider your health to be: ☐ Excellent, ☐ Good, ☐ Fair, ☐ Poor

Date of Last Physical Exam: ___________________ Physician: ________________

Reason for Today's Visit: ____

Current Physician: _______________ Who Recommended you to us? ____________

(Patient/Guardian) **Signature: ________________________________ Date:____________**

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CONSENT TO TREAT

Please circle Yes or No:

Were you injured on the job?	Yes	No
Have you filed a work comp. claim?	Yes	No
Were you involved in a Motor Vehicle Accident?	Yes	No
Is this injury involved in litigation?	Yes	No

*We DO NOT accept liens against pending legal settlements.

If you have an Attorney, please fill out the following:
Name of Attorney: ____
Phone: __________________ Fax: __________________
Address (include city, state & zip): ____

Have you had any Physical Therapy this year at another clinic?	Yes	No
If yes, how many visits? _____		
Have you had any Chiropractic visits?	Yes	No
If yes, how many visits? _____		

Missed Appointments:
Please notify us at least 24 hours in advance if you cannot keep your scheduled appointment in order for us to be able to fill your appointment time. Cancellations or missed appointments without 24 hour notice are subject to a charge equal to the amount of the appointment.
I, ______________________, have read and understand that I remain responsible for the total amount due to Folsom
(PRINT NAME HERE)
Physical Therapy for their services and policies, such as that listed above. I, the undersigned, do hereby agree and give my consent to Folsom Physical Therapy to furnish my medical care and treatment considered necessary and proper in assessing or treating my physical condition.

I hereby assign all medical benefits to Folsom Physical Therapy and authorize release of all information necessary to secure payment. A photocopy should be considered valid.

(Patient/Guardian)Signature_____________________________ Date: _______________________