

Initial Health Status

Sports Massage of Portland
 3430 SE Belmont #105, Portland, OR 97214
 503.381.7557 Fax 503.548.4698

Patient Name: _____ Birthdate: _____ Sex: M / F
 Address: _____ City: _____ State: _____ Zip: _____
 Telephone: _____ Social Security #: _____ Driver Lic. # _____
 Occupation: _____ Employer: _____ Work Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Subscriber Name: _____ Health Plan: _____
 Subscriber ID#: _____ Group #: _____ Spouse Name: _____
 Spouse Employer: _____ City: _____ State: _____ Zip: _____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Mark an X on the picture where you have pain or other symptoms.

Is this? Work Related Auto Related N / A

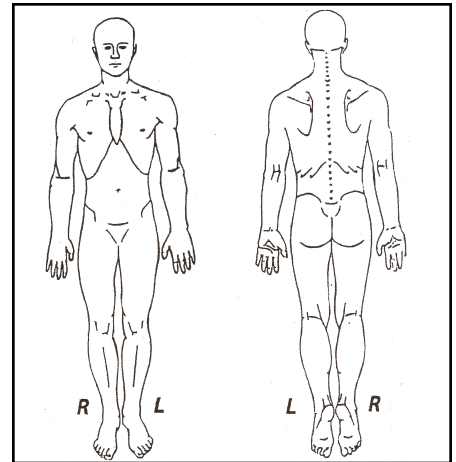
DATE INJURY BEGAN: _____ **CLAIM #** _____

Claim Representative: _____ **Phone:** _____

Claims Office Address: _____

City: _____ **State:** _____ **Zip:** _____

Referring Physician: _____ **Phone:** _____



Current Complaint (how do you feel today?)										
0	1	2	3	4	5	6	7	8	9	10
No Pain						Unbearable Pain				

Can you perform daily activities? Yes No (Describe) _____

How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%

HAVE YOU HAD X-RAYS, MRI, CT SCAN? NO YES **WHAT WERE RESULTS?** _____

ARE YOU ON ANY MEDICATION? NO YES **LIST:** _____

Please check the following that apply to you:

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (date) _____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problem	<input type="checkbox"/>	<input type="checkbox"/>	Do you Smoke
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Use caffeine
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	Surgeries If yes, where? _____						
<input type="checkbox"/>	<input type="checkbox"/>	Cancer If yes, where? _____						

Any other condition that might be aggravated by Massage Therapy? Yes No

If Yes, explain: _____

I certify that the above information is complete and accurate. If the health information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient/Guardian Signature: _____ Date: _____