**1136 Jacklin Road**
**Milpitas, CA 95035**
**408-262-1371**
www.THRIVEMILPITAS.com
info@thrivemilpitas.com

## Patient Information

| | | |
|---|---|---|
| **First Name:** | **Middle:** | **Last:** |
| **Gender:** · **Female** · **Male** | | |
| **Street:** | | **City:** |
| **Prov/State:** | **Country:** | **Postal Code:** |
| **Date of Birth:** Month / Day / Year | **Best way to contact you:** Cell/Home/E-mail | |
| **Home Telephone:** | **Cell Telephone:** | |
| **Email Address:** | **Work Telephone:** | **Ext:** |

***How did you hear about us?*** · **Yelp!** · **Google** · **Yahoo!** · **Our Website**

## Emergency contact information

**Emergency Telephone**:

**Emergency Contact Name:**

**Did you know that *most* PPO Insurances Pay for your Treatment at our Office?**
**PLEASE ask our Amazing Staff for more details, or provide your information below:**

## Insurance information

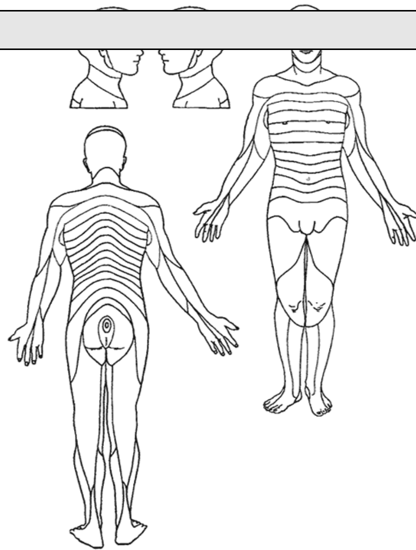
| | |
|---|---|
| **Member ID:** | **Carrier Phone:** |
| **Group Number:** | **Case/Claim number:** |

| **Date of last examination** | | | |
|---|---|---|---|
| ·Chiropractic | · Less than 6 months | · 6 months to 1 year | · 1 to 2 years |
| ·Physical examination : | · Less than 6 months | · 6 months to 1 year | · 1 to 2 years |
| ·X-Ray examination : | · Less than 6 months | · 6 months to 1 year | · 1 to 2 years |
| ·Blood tests : | · Less than 6 months | · 6 months to 1 year | · 1 to 2 years |
| ·Urine tests : | · Less than 6 months | · 6 months to 1 year | · 1 to 2 years |

| **Trauma History** | · Surgeries | **Exercise** |
|---|---|---|
| · Falls | · Auto accidents | · None |
| · Head injuries | · Other 1 | · Moderate |
| · Broken bones | · Other 2 | · Heavy |
| · Dislocation | · Other 3 | · 1-2 · 3-4 · 5-7 Days a Week |
| | | · <30 · 30-60 · >60 min a day |
| **Current Medication** | · Blood pressure | |
| · Anti- inflammatory | · Other Medications: | |
| · Pain killers | · Muscle relaxant | |

| **Work activity** | **Sleeping position** | **Hours of sleep** |
|---|---|---|
| · None | · Back | · 1-3 |
| · Sedentary | · Side | · 4-6 |
| · Moderate | · Stomach | · 7-9 |
| · Heavy | · Varies | · More than 10 |

| Current Health Concerns (Please select only one severity) | | | | |
|---|---|---|---|---|
| 1. | ·Irritability | ·Mild | ·Moderate | ·Severe |
| 2. | ·Arm Pain | ·Mild | ·Moderate | ·Severe |
| 3. | ·Neck Pain | ·Mild | ·Moderate | ·Severe |
| 4. | ·Back Pain | ·Mild | ·Moderate | ·Severe |
| 5. | ·Leg Pain | ·Mild | ·Moderate | ·Severe |
| 6. | ·Headache | ·Mild | ·Moderate | ·Severe |
| 7. | ·Bad Posture | ·Mild | ·Moderate | ·Severe |
| 8. | ·Meningitis | ·Mild | ·Moderate | ·Severe |
| 9. | ·Migraines | ·Mild | ·Moderate | ·Severe |
| 10. | ·Sciatic Nerve | ·Mild | ·Moderate | ·Severe |
| 11. | ·Joint Pains | ·Mild | ·Moderate | ·Severe |
| 12. | ·Numbness | ·Mild | ·Moderate | ·Severe |
| 13. | ·Carpel tunnel | ·Mild | ·Moderate | ·Severe |
| 24. | OTHER: | | | |



## Massage / Acupuncture Therapy Services' Consent Form

*THIS FORM **MUST** BE COMPLETED & SIGNED BEFORE RECEIVING A MASSAGE / ACUPUNCTURE.*

Have you ever experienced a professional Massage / Acupuncture? ________________________________________

Which areas would you like to focus on during this Massage / Acupuncture? _________________________________

Do you have any of the following conditions? If yes, please explain to therapist as clearly as possible.

______ Stress ______ Allergies ______ Contagious disease
______ Diabetes ______ Wear contact lenses ______ Back pain
______ Pregnant ______ Cancer ______ Cardiac/circulatory problems
______ Arthritis ______ Frequent headaches ______ Sensitive to touch or pressure
______ Osteoporosis ______ Epilepsy or seizures ______ Bruise easily
______ Joint swelling ______ Varicose veins ______ Depression
______ Other medical conditions not listed. Explain:________________________________________

I understand that the Massage / Acupuncture I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that Massage / Acupuncture should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that the therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because Massage / Acupuncture should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapist reserves the right to refuse to perform treatment on anyone whom he/she deems to have a condition for which is contraindicated.

**Cancellation Policy-** ***For appointments with a licensed acupuncturist and/or massage therapist, any cancellations made with less than 24 hour notice will result in $20 fee per 30 minutes of massage/acupuncture.***

Client Signature ________________________________________ Date ____________________