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

___ allergies	___ endometriosis	___ HIV/AIDS	___ migraine
___ anemia	___ epilepsy	___ hypertension	___osteoporosis
___ arthritis	___ fibromyalgia	___ hyperthyroid	___ phlebitis
___ asthma	___ gout	___ hypoglycemia	___ sinusitis
___ cancer	___ heart disease	___ hypothyroid	___ stroke
___ chronic infection	___ herpes	___ indigestion	___ tinnitus
___ constipation	___ hiatal hernia	___ irritable bowel	___ tuberculosis
___ diabetes			

Other conditions: ____

Do you have any of the following symptoms?

___ intolerance of cold	___ feeling of anxiety	___ stuffy feeling in ears or loss of hearing
___ intolerance of heat	___ dry, rough skin	
___ chronic fatigue	___ rapid heart rate	___ blurred vision
___ depression	___ nausea	___ unexplained pain in teeth
___ increase in pain with onset cold, rainy weather	___ headaches (how often?___)	___ diarrhea
	___ dizziness	___ numbness (where? _____)
___ high cholesterol	___veering to one side while walking or driving	___ unusual weakness (where?________________)
___ sweating		
___ trembling or shaking	___ 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 ____________

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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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(703) 548-2270

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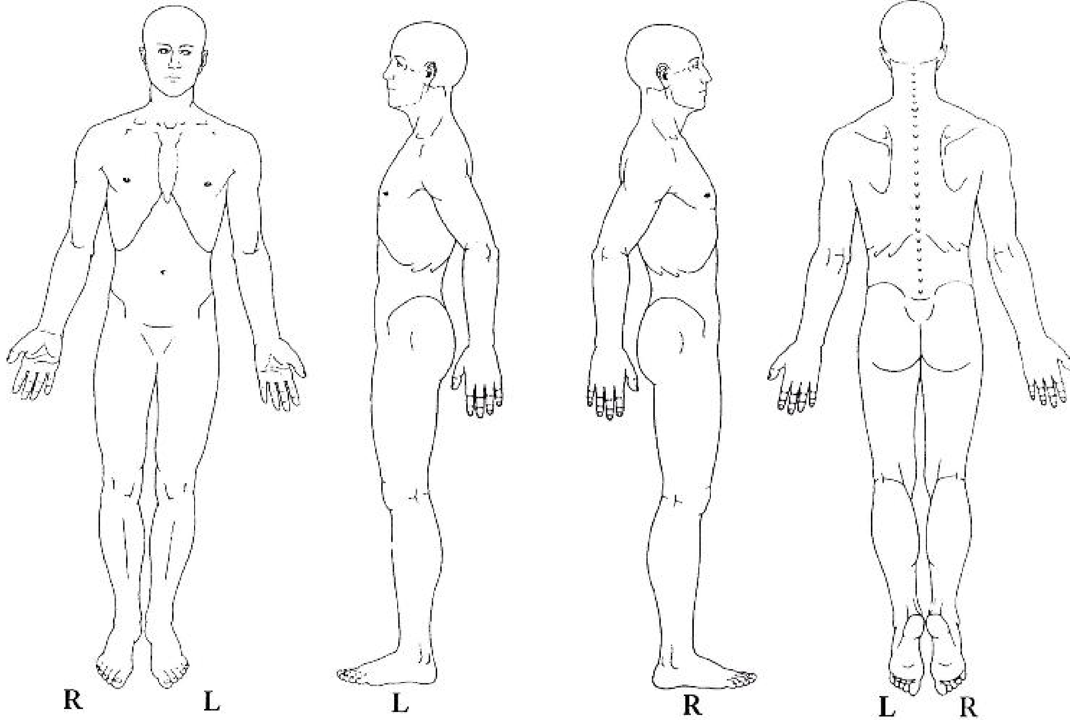
Name ____________________
Date _____/_____/_____



Which pain 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 also 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.