Performance
Physical Therapy + Fitness

Hockessin
Stone Mill Plaza
720 Yorklyn Road
Suite 150
Hockessin, DE 19707

302 234 2288 TEL
302 234 2869 FAX

N. Wilmington
Lombardy Center
410 Foulk Road
Suite 106
Wilmington, DE 19803

302 764 2288 TEL
302 234 2869 FAX

Mill Creek
Mill Creek Medical Center
4512 Kirkwood Highway
Suite 101
Wilmington, DE 19808

302 254 2288 TEL
302 234 2869 FAX

www
pptandfitness.com

MASSAGE PATIENT INFORMATION

Patient account number _____

Name (Last) _____ **(First)** _____ **(MI)** _____
Address _____
City_____ **State**_____ **Zip**_____
Home Phone (____) _____**Work (____)**_____
E Mail Address _____
Date of Birth ____/____/_____ **Age**_____

Emergency Contact:

Name_____ **Phone#** _____
Relationship_____

Please Read Carefully and Sign Below

Client Agreement

1. I will provide payment for massage services on the date of the session. PPT, Inc. does not submit fees for these services to insurance for payment. Records of my account are available upon request.
2. I have provided accurate and current personal and health information and will continue to do so.
3. I understand that massage/bodywork is for the purpose of stress reduction and general relaxation, relief from soft tissue tension and spasm, and does not constitute medical treatment. The massage therapist will not diagnose illness, disease or any other physical or mental disorder, will not prescribe medical treatment or pharmaceuticals nor perform any spinal manipulations.
4. **If unable to keep this appointment kindly give 24 hours notice otherwise charge will be made for time reserved.**

Signature_____ **Date**_____

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Name: _____

Date: _____

Do you have or have you had any of the following? Please check YES or NO.

	YES	NO
HEART PROBLEMS		
HIGH BLOOD PRESSURE		
CANCER		
CHEST PAIN		
CIRCULATORY PROBLEMS		
DIABETES		
RESPIRATORY PROBLEMS		
NEUROLOGICAL PROBLEMS		
ORTHOPEDIC PROBLEMS		
SURGERY		
SEIZURES		

EXPLAIN: _____

Do you have any metal implants? (pacemaker, IUD, screws, or total joint replacements): _____

Do you wear dentures?: _____

Are you pregnant or trying to become pregnant?: _____

Have you ever received physical therapy before? If so, for what type of problem? _____

Why type of treatment did you receive? Was it helpful? _____

_____

_____

Are you on any medications now? If so, please list: _____

_____

_____