Navesink Wellness Center
61 Carton Street
Rumson, New Jersey 07760
732-533-4224

Patient Information

Name: _____ **Date of Birth:**_____

Address: _____

_____

We routinely communicate with patients over the phone or via email to schedule and confirm appointments or to discuss specific information regarding treatment. Please indicate which telephone numbers or email addresses we can contact you on by checking the appropriate boxes.

Home Phone Number: _____ ☐

Cell Phone Number: _____ ☐

Work Phone Number:_____ ☐

Email Address: _____ ☐

General Medical History

Are you currently pregnant? Y N

Do you have any allergies or skin sensitivies? Y N

*Please explain:*_____

Are you currently on any medication? Y N

*Please explain:*_____

Have you had any surgeries or chronic illness? Y N

*Please explain:*_____

Please check all that apply:

___Anxiety
___Arthritis
____ Asthema
___Cancer
___Depression
___Diabetes
___Epilepsy
___Headaches
___Heart Disease
___Hemophilia
___High Blood Pressure
___Low Blood Pressure
___Lymphatic Condition
___Pacemaker
___Varicose Veins

Please Rate on Scale of 1-10 (10 = highest)

_____ Stress
_____Pain
_____Energy

Limits of Confidentiality

All information regarding patients, their treatments, diagnosis and appointments is kept strictly confidential within the confines of Navesink Wellness Center. To provide the most adequate and comprehensive treatment, patient information may be discussed amongst involved NWC practitioners. Discussion of treatment is always confined to treatment room, not in the presence of other patients.

Disclosure

I understand that the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension or spasm, and / or improving circulation. I understand that a massage therapist neither diagnoses illness, disease or any other medical, physical or mental disorders; nor performs any spinal manipulation. I am responsible for consulting a qualified physician for any physical ailment I may have.

Signature:_____ Date:_____