Infinity Dreamscapes

# New Patient Registration Form

Last Name: _____ Middle: _____ First Name: _____
DOB: ___/___/_____ Gender (circle): F M Minor (Circle): Yes No
Address: _____
City: _____ State: _____ Zip: _____ Country: _____
Email: _____@ gmail.com yahoo.com icloud.com
net.com aol.com outlook.com
Other (Specify):_____
Have you ever had a Professional Massage Before? Y N Date of Last: ____/____/_____

**Authorized Emergency Contact**
Last Name: _____ First Name: _____ Relationship: _____
Phone: _____

Select To Disclosed (Circle):
Appointment Reminders Medical Information Billing Information

**How did you Hear about us:**

Referred By Primary Care Provider (Circle): Yes No
If Yes, Referred By (Name):_____
Organization: _____
Last Visit Date: ____/____/_____

Referred By OBGYN (Circle): Yes No
If Yes, Referred By (Name): _____
Organization: _____
Last Visit Date:____/____/_____
Are you Currently Pregnant: Yes No
If Yes, (Circle Trimester)
First Trimester Second Trimester Third Trimester
High Risk Factors (Please Specify: _____

Referred by Speciality Provider (Circle): Yes No
If Yes, Referred By (Name or Organization):_____
Referral Date: ____/____/_____

Online (Specify Resource): _____
Other (Specify): _____

_____ **(Print First, Middle Initial, Last Name)**

_____ **Date:** ____/____/_____
**(Signature)**

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# Intake Forms

Last Name: _____ Middle: _____ First Name: _____
DOB: ___/___/_____ Gender (circle): F M Minor (Circle): Yes No
Address: _____
City: _____ State: _____ Zip: _____ Country: _____

Indicate Health Conditions that apply to you:

| | | | | | |
|---|---|---|---|---|---|
| Pacemaker: | Yes | No | High/ Low Blood Pressure: | Yes | No |
| Blood Clots: | Yes | No | Cancer: | Yes | No |
| Diabetes: | Yes | No | Heart Attack: | Yes | No |
| | | | Fibromyalgia: | Yes | No |

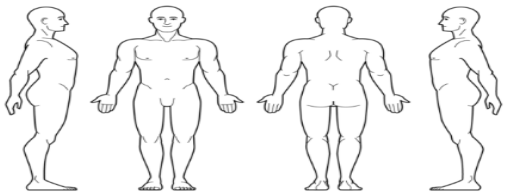
Arthritis: Yes No
If yes, Specify: _____
Disorders: Yes No
If yes, Specify: _____

Are you taking Medications? Yes No
Do you have Allergies or Sensitivities? Yes No
If Yes, Please Specify: _____

History of Surgeries: Yes No
Recent Date of Surgeries: ____/____/_____ Upcoming Surgery Date: ____/____/_____
Do you have any Injuries? Yes No
Area of Surgeries (Circle): Dates:

| | | | | | |
|---|---|---|---|---|---|
| Shoulder: | Left | Right | None | | ____/____/_____ |
| Elbow: | Left | Right | None | | ____/____/_____ |
| Wrist: | Left | Right | None | | ____/____/_____ |
| Hip: | Left | Right | None | | ____/____/_____ |
| Knee: | Left | Right | None | | ____/____/_____ |
| Ankle: | Left | Right | None | | ____/____/_____ |
| Foot: | Left | Right | None | | ____/____/_____ |
| Spine: Cervical | | Thoracic | Lumbar | Sacrum | ____/____/_____ |

Indicate Focus Area



_____ **Date:** ____/____/_____
**(Signature)**

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