CENTER FOR LIFE

Dear Valued Patient,
Thank you for choosing the UNM Center for Life (CFL) for massage therapy. We're committed to providing you excellent care.

Name: _____ DOB: _____ Gender: Male / Female

Address: _____ City: _____ State: ____ Zip Code: _____
Phone Number: 1st Choice: _____ 2ND Choice: _____

Your experience at the Center for Life is important to us. Additionally, healthcare law now requires that we obtain and federally report patient satisfaction data. Southwind, a national surveyor, contacts a number of patients every month and may contact you. If contacted, you may choose to receive / complete the survey electronically or over the phone.

- If you would like to receive the survey electronically, please provide your email address.

Email Address: _____

- Would you also like to receive the CFL newsletter and be notified of upcoming events at this email address?
  O Yes No

Provider History:
Are you currently seeing a medical or other health care practitioner? Provider: _____
Provider: _____

Medical History: (Please circle conditions that apply and identify if they are past or present.)

Condition	Past	Present	Describe:
Cardiovascular	Past	Present	Describe:
Cancer	Past	Present	Describe:
Respirator or Lung	Past	Present	Describe:
Diabetes	Past	Present	Describe:
Injuries or Surgeries	Past	Present	Describe:
Lymph Node Removal?	Yes	No	Describe:
Digestive	Past	Present	Describe:
Liver or Kidney	Past	Present	Describe:
Autoimmune	Past	Present	Describe:
Bone or Joint Conditions	Past	Present	Describe:
Other	Past	Present	Describe:

Allergies: (Do you have any allergies?)
1. _____ 2. _____

Massage History:

- Have you ever had a professional massage before? Yes/No Date of Last Massage: _____
- Is there anything you liked or disliked from previous massages? _____
- Would you prefer a massage with lotion or oil? Lotion Oil
- What results would you like from your massage? _____

Preventive Care History:

Do you exercise or practice stress reduction activities?	Activity:	How often:	For how long:

Do you see a counselor or attend support group meetings?	Yes	No

Medication History:

Please list any:	Medication/OTC/Health Product	Dose	Frequency
1. **Prescription** (Rx)	1.		
	2.		
2. **Over-the-Counter**	3.		
	4.		
3. **Natural health products** (vitamins)	5.		
	6.		
	7.		
	8.		
	9.		

Thank you for taking the time to share this information with us. We look forward to providing you excellent care. For more information about the

Center for Life, please visit our website at **www.unmcfl.org.**

Are you experiencing pain or discomfort? Color in the areas where you feel it.