

CONFIDENTIAL PATIENT INFORMATION

Full Name _____ SS# _____ Date _____
Address _____
City _____ State _____ Zip _____ (H) Phone _____
Work Phone _____ Cell Phone _____
Fax # _____ Email Address _____
Age _____ DOB _____ S M D W Name of Spouse or Parent _____
Name of Children with ages _____
Employer _____ Occupation _____ Yrs. On Job _____
Employer's Address _____ City _____
State _____ Zip _____ How were you referred to our office? _____

ABOUT YOUR MASSAGE

If you are scheduling to receive a wellness / relaxation massage and do not have any specific areas of concern, please skip the following 8 questions.

1. What area do you want the massage therapist to focus on? _____
2. Describe your discomfort. (Ex. Pain, muscle spasm, tightness) _____

3. When and how did this begin? _____

4. How often do you notice the above concerns? _____
5. Describe the nature of your symptoms. (circle) Sharp, Dull Ache, Numb, Shooting, Burning, Tingling
6. How are your symptoms changing? (circle) Getting Better, Not Changing, Getting Worse
7. In general how is your overall health? (circle) Excellent, Very Good, Good, Fair, Poor
8. Have you had similar symptoms in the past? (circle) Yes / No
 - a. If you had treatment in the past for the same or similar symptoms, who did you see? (circle)
No One, Other Chiropractor, Medical Doctor, Physical Therapist, Massage Therapist, Other

OTHER BODY SIGNALS

Check all that apply: (A) Past (B) Present (C) Recurring

A	B	C	A	B	C	A	B	C			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	Pins & Needles in Legs	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain/Stiffness	Pins & Needles in Arms	Hands or Feet Cold
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Problems	Numbness in Fingers	Stomach Upset
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	Numbness in Toes	Constipation/Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	Loss of Balance	Nervousness/Tension
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	Depression	Skin Conditions / Rashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	History of Cancer	Dizziness/Fainting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	Stroke	Bruise Easily

What medications are you taking, if any, for what symptom(s) and for how long? _____

Have you had surgery? Y / N If yes what & when? _____

List all side effects, if any, you experienced from the above medications and/or surgery? _____

ABOUT YOUR VISIT

Notice to our new patients: It is our policy to collect payment for services as they are rendered until payment arrangements have been made and/or insurance is verified. I agree to pay for services rendered as the charge is incurred and will pay for today's visit, if a fee applies, with (circle one) Cash Check MC / Visa / Discover

Should the Doctor find anything he's concerned about he may recommend taking x-rays and, if you choose to do that, there would be a nominal fee of \$27 to cover the cost of the film.*

In order to avoid a missed appointment fee of \$25, please call in advance if you are unable to keep your appointment.

I authorize the Doctors and staff of this office to examine, x-ray, and provide care to me as they deem necessary.

Patient's Signature _____ Date _____

I authorize the Doctors and staff of this office to examine, x-ray, and provide care to my child as they deem necessary.

Guardian's Signature _____ Date _____

* This is not valid with Medicare, Automobile Accidents, and Worker's Compensation claims.