Client Health Record - Massage

CLIENT INFORMATION

NAME:		DATE:
PREFERRED NAME / NICKNAME:		
ADDRESS:		
CITY:	STATE/ZIP CODE:	
HOME PHONE:	CELL PHONE:	
EMAIL ADDRESS:		
DATE OF BIRTH:	AGE:	GENDER: M F

□ DIVORCED □ MARRIED □ SEPARATED □ SINGLE □ WIDOWED

SPOUSE'S NAME:

CHILDREN'S NAMES & AGES:

HOW DID YOU HEAR ABOUT OUR OFFICE?

MASSAGE INFORMATION

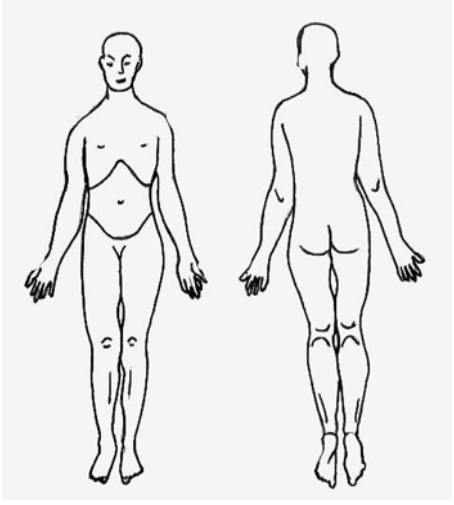
HAVE YOU EVER HAD A PROFESSIONAL MASSAGE? □ YES □ NO

WHAT TYPE OF PRESSURE DO YOU PREFER?

□ LIGHT □ MEDIUM □ FIRM

ARE THERE ANY AREAS THAT YOU WOULD ***NOT*** LIKE WORKED ON?

CIRCLE ANY AREAS YOU WOULD LIKE TO CONCENTRATED ON:



REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

WHEN DID THIS CONDITION BEGIN?

HAVE YOU SEEN A DOCTOR(S) FOR THIS CONDITION? □ YES □ NO

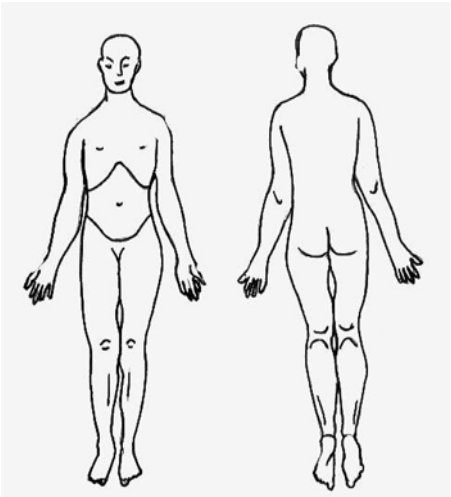
DOCTOR'S NAME AND SPECIALTY:

TYPE OF TREATMENT:

PLEASE LIST ANY OTHER CONDITIONS YOU FEEL WE SHOULD KNOW ABOUT EVEN IF UNRELATED:

WRITE THE LETTERS ON THE PICTURE BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW:

A = ACHE
B = BURNING
N = NUMBNESS
O = OTHER
P = PINS AND NEEDLES
S = STABBING



Nobbe Family Chiropractic
2805 N Center, PO Box 831
Maryville, IL 62062
(618) 288-5091

CLIENT NAME:
DATE:

HEALTH HISTORY

HAVE YOU HAD OR CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

□ **DENY ANY ISSUES**

□ ACUTE PAIN
□ ALLERGIES / SENSITIVITIES
□ ARTHRITIS
□ ARTIFICIAL JOINT / DISORDER
□ BLOOD CLOTS
□ CANCER: TYPE_____
□ CARPAL TUNNEL SYNDROME
□ CHRONIC PAIN
□ CIRCULATORY DISORDER
□ CONTAGIOUS SKIN DISORDER
□ CURRENTLY PREGNANT
□ DECREASED SENSATION
□ DEPRESSION
□ DIABETES
□ EASY BRUSING
□ EPILEPSY
□ FIBROMYALGIA
□ HEADACHES / MIGRAINES
□ HEART CONDITION
□ HIGH / LOW BLOOD PRESSURE
□ HIV
□ INFECTIOUS CONDITION
□ LUPUS
□ MULTIPLE SCLEROSIS
□ OPEN SORE / WOUND
□ OSTEOPOROSIS
□ PTSD / PANIC / ANXIETY
□ SCOLIOSIS
□ SPINA BIFIDA
□ STROKE
□ SWOLLEN GLANDS
□ TENDONITIS
□ TMJ
□ VARICOSE VEINS

□ OTHER:_____ □ OTHER:_____

INJURIES: □ **DENY ANY ISSUES**

□ BACK / NECK INJURY
□ FRACTURE
□ SEVERE FALL
□ SOFT TISSUE INJURY

□ OTHER:_____ □ OTHER:_____

LIST PRESCRIPTION MEDICATION / VITAMINS:

CANCELLATION / NO SHOW

A 24 HOUR NOTICE MUST BE GIVEN IF YOU ARE UNABLE TO KEEP AN APPOINTMENT.

IN THE CASE OF A SHORT NOTICE OR NO NOTICE CANCELLATION, THE FULL AMOUNT FOR THE SCHEDULED TIME WILL BE CHARGED TO THE CLIENT'S ACCOUNT.

PAST DUE ACCOUNTS

AFTER 60 DAYS OF NON-PAYMENT, A $25 LATE FEE WILL BE ADDED AND COMPOUND MONTHLY.

IF NECESSARY, THE ACCOUNT WILL BE TURNED OVER TO A COLLECTION AGENCY AND A COLLECTION FEE OF 30% WILL BE ADDED TO YOUR BALANCE.

AS A LAST RESORT, LEGAL ACTION WILL BE TAKEN. ALL REASONABLE ATTORNEYS AND COURT FEES INCURRED TO COLLECT PAST DUE ACCOUNTS WILL BE ADDED TO THE ACCOUNT AND THE CLIENT WILL BE RESPONSIBLE.

INFORMED CONSENT

I UNDERSTAND THAT THE MASSAGE I RECEIVE IS PROVIDED FOR THE BASIC PURPOSE OF RELAXATION AND RELIEF OF MUSCULAR TENSION. IF I EXPERIENCE ANY PAIN OR DISCOMFORT DURING THE SESSION, I WILL IMMEDIATELY INFORM THE THERAPIST SO THAT THE PRESUURE AND/OR TYPE OF STROKE MAY BE ADJUSTED TO MY LEVEL OF COMFORT. I UNDERSTAND THAT MASSAGE IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATIN, AND THAT MASSAGE THERAPISTS ARE NOT QUALIFIED TO DIAGNOSIS MEDICAL CONDITIONS, PERFORM ANY SPINAL MANIPULATIONS OR PRESCRIBE TREATMENTS. I HAVE STATED ALL KNOWN MEDICAL CONDITIONS AND ANSWERED ALL QUESTIONS, WRITTEN AND VERBAL, HONESTLY. I AGREE TO KEEP THE MASSAGE THERAPIST UPDATED WITH ANY CHANGES IN MY MEDICAL PROFILE AND UNDERSTAND THAT THERE SHALL BE NO LIABILITY TO THE THERAPIST IF I FAIL TO DO SO.

CLIENT NAME (PLEASE PRINT):	RELATIONSHIP TO CLIENT:
SIGNATURE:	DATE:

Nobbe Family Chiropractic
2805 N Center, PO Box 831
Maryville, IL 62062
(618) 288-5091

THANK YOU FOR CHOOSING NOBBE FAMILY CHIROPRACTIC