WELCOME TO OUR OFFICE!

Name ____ Cell Phone (_____)______-________

Address ____ Home Phone (_____)______-________

City, State, Zip Code _________________________________ Birth Date ______________________

Social Security # _______-______-__________ Age _______ Email ______________________________

Sex: ☐ Male ☐ Female If you are female, are you pregnant? ☐ No ☐ Yes

Who can we thank for referring you to our office? ☐ Chair Massage Event ________________________
☐ Referred by ____ ☐ Internet ☐ Driving by

Occupation ____________________________ Employer ____________________________________

Spouse's Name _____________________________ Spouse's Employer ___________________________

Emergency Contact name and phone number ______________________________ (_____)_____-________

Please list any previous surgeries and the year performed:

____

____

What medication(s) are your currently taking and for what condition(s)?

____

____

Please list the year of any car accidents or hospitalizations:

____

____

If you have Health Insurance, what is the name and Birth Date of the Primary Insured? ☐ No Insurance
Name: ____ Date of Birth: ________________________

Please check-off any off these that apply to you:
☐ Arthritis ☐ Osteoporosis ☐ Anemia ☐ Diabetes ☐ Hepatitis ☐ Skin Problems
☐ Painful Sneezing or Coughing ☐ Stroke ☐ Fainting ☐ Tremors ☐ Muscle Weakness
☐ Smoke ☐ Drink Alcohol ☐ HIV/ AIDS ☐ Cancer: ______________________________________
Other/ further details: ____

Does anyone in your family have a history of:
☐ Headaches ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Cancer: _______________

Please UNDERLINE any Past Conditions and CIRCLE any Current Conditions.

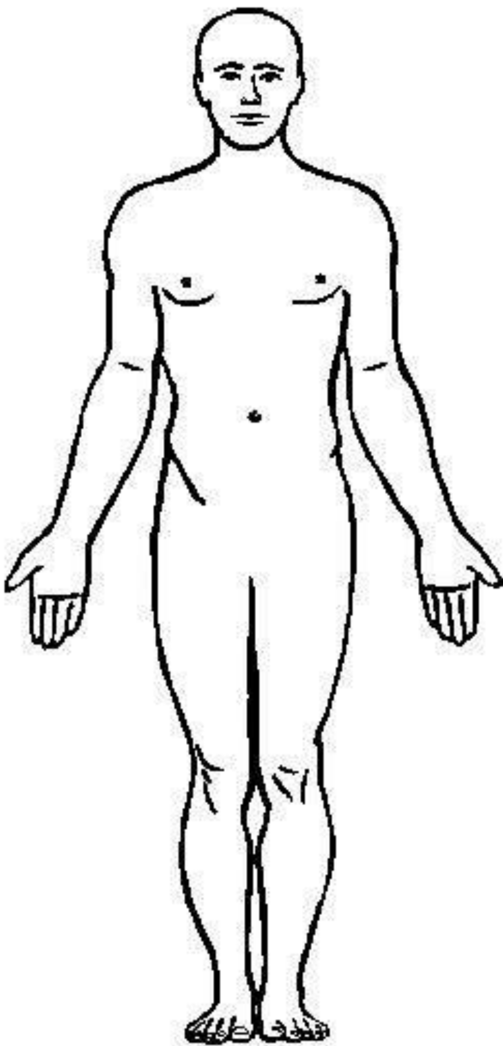
Segment	Conditions
☐C1 ☐C2 ☐C3 ☐C4 ☐C5 ☐C6 ☐C7	●Neck Pain/ Stiffness ●Headaches/ Migraines ●Arm/Hand Numbness ●Carpal Tunnel ●Sinus Congestion ●Ear Infections ●Allergies ●Asthma ●Trouble Sleeping ●High Blood Pressure ●Low Blood Pressure ●High Cholesterol ●Depression ●Vision Problems ●Seizures/ Epilepsy ●Dizziness ●Fatigue ●Thyroid Condition
☐T1 ☐T2 ☐T3 ☐T4 ☐T5 ☐T6 ☐T7 ☐T8 ☐T9 ☐T10 ☐T11 ☐T12	●Mid-back Pain/ Stiffness ●Difficulty Breathing ●Chest Pain ●Shoulder Pain ●Shoulder Bursitis/ Tendonitis ●Bronchitis ●Pneumonia ●Heartburn ●Heart Condition ●Gastritis ●Ulcers ●Acid Reflux ●Lung/ Respiratory Problems ●Gallbladder Conditions ●Indigestion/ Upset Stomach ●Kidney Problems ●Liver Conditions ●Jaundice
☐L1 ☐L2 ☐L3 ☐L4 ☐L5 ☐RSI ☐Sacrum ☐Coccyx ☐LSI	●Low Back Pain/ Stiffness ●Back Spasms ●Sciatica ●Numbness/ Tingling in Legs or Feet ●Irritable Bowel Syndrome ●Constipation ●Diarrhea ●Bladder Problems ●Colitis ●Menstrual Problems ●Leg/ Foot Weakness

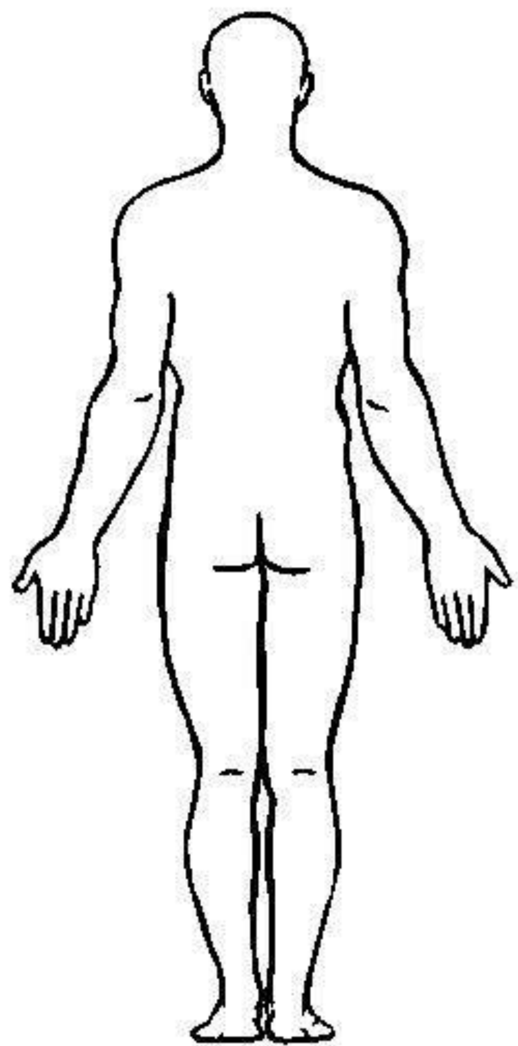
Pain Diagram

Please use the letters to indicate where all your discomfort is on the drawing below.

P = Pain
A = Achy
B = Burning
T = Tingling
X = Sharp-Shooting
S = Stiffness
N = Numbness

Right Left Right





Health Status

Please place an "**X**" next to any Current conditions and a "**P**" next to any Past conditions

___ Neck Pain/ Stiffness ___ Mid-back Pain/ Stiffness ___ Low Back Pain/ Stiffness

___ Shoulder Pain ___ Elbow Pain ___ Pelvis/ Gluteus Pain

___ Hand/ Wrist Pain ___ Knee Pain ___ Hip Joint Pain

___ Ankle/ Foot Pain Other____

Which condition is your main concern? ______________________________________

How did it occur? ____

How long ago did this start? ____

It occurred: ☐ Suddenly ☐ Gradually

How would you describe it? ☐ Tight ☐ Deep ☐ Superficial ☐ Radiating ☐ Throbbing

On a scale from 1 to 10 (10 being the worst), how does it feel NOW? **1 2 3 4 5 6 7 8 9 10**

On a scale from 1 to 10, what is the WORST it has felt? **1 2 3 4 5 6 7 8 9 10**

Have you experienced this problem in the past? ____________________________

Is the problem getting: ☐ Worse ☐ Better ☐ Staying the same

Does the problem seem: ☐ Worse in morning ☐ Worse at night ☐ Worse after work
☐ No predictable pattern ☐ Constant ☐ On and off

What makes it worse? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Twisting
☐ Laying face-up ☐ Laying face-down ☐ Laying on side: _______________

What makes it better? ☐ Rest ☐ Ice ☐ Heat ☐ Massages ☐ Stretches
☐ Advil, Ibuprofen, Tylenol, Excedrin, etc. Other ____________________________

What previous treatments have you had in the past?
☐ Chiropractic ☐ Massage ☐ Physical Therapy ☐ Injections ☐ Surgery ☐ Acupuncture
Other ____

The above information is true and accurate to the best of my knowledge.

Patient Signature ______________________________ **Date**____________________