New Patient Information

Patient # _________________________ Phone # ____________________________ Work # ______________________________

Name (Last, First, MI) ____ E-mail ______________________________

Address ____

City/State/Zip ____

DOB _______/_______/_______ Age _______________ Sex: M F Height: _______________ Weight: ______________

Employer: ____ Type of Work: ____

SS # ___________________________ Spouse ____ # of Children ___________

Names/Ages of Children ____

Referred to This Office By: ______________________________________ Relation To Patient ____________________________

Primary Ins. ____ Secondary Ins. ____

The Chiropractic Experience: A Creating Wellness Center
Massage Health Form
Patient Name: ______________________________ Date: ____________

A. Health Information
Primary Health Care Provider
Name ______________________________
City ____________ State _____ Zip _____
Phone: (____) _________Fax (____) ________

List all conditions currently monitored by a Health Care Provider ____________________
____
____

List the medications you currently take (include pain relievers and herbal remedies)
____
____
____

List any surgeries/illnesses (include dates)
____
____
____
____

I give my massage therapist permission to consult my health care provider regarding my health and treatment.
Initials __________ Date ___________

B. Current Health Information
Concerns – Check all that apply (areas you wish more time to be spent on)

Primary ______________________________
___mild ___moderate ___intense
___ Constant ___intermittent
___↑w/activity ___↓w/activity
Pain rate ___ (10 being in extreme pain)

Secondary______________________________
___mild ___moderate ___intense
___ Constant ___intermittent
___↑w/activity ___↓w/activity
Pain rate ___ (10 being in extreme pain)

Additional________________________
___mild ___moderate ___intense
___ Constant ___intermittent
___↑w/activity ___↓w/activity
Pain rate ___ (10 being in extreme pain)

Have you ever received massage therapy before? ___ Y ___N
Frequency? ____________________________
How do you reduce stress? ______________
____
____
What are your goals for receiving massage therapy today? ______________________
____
Any place you wish not to be massaged?
____

C. Daily Activities
Occupation: ___________________________
Home:_______________________________
Family ______________________________
Social _______________________________
Recreational __________________________

D. Office Policies

In order to be fair to our massage therapist and our clients, we set forth the following office policies:

We request 24 hours for any cancellations. A one time grace warning will be given after which for cancelled appointments will be charged in full to your account. Insurance will not pay for cancelled appointments. If you can have a replacement in your stead, your account will not be charged.

I have read the office policies and agree to abide by them: ______________________

<u>Check All Current and Previous Conditions</u> <u>Please Explain HEALTH INFORMATION</u>

C= Current P= Past

General

C P comments

- ☐ ☐ Headaches ________________
- ☐ ☐ Pain ______________________
- ☐ ☐ Sleep disturbance ___________
- ☐ ☐ Fatigue ___________________
- ☐ ☐ Infectious _________________
- ☐ ☐ Fever _____________________
- ☐ ☐ Sinus _____________________
- ☐ ☐ Other _____________________

Skin Conditions

C P comments

- ☐ ☐ Rashes ____________________
- ☐ ☐ Athlete's foot warts _________
- ☐ ☐ Other _____________________

Allergies

C P comments

- ☐ ☐ Scents, oils, lotions _________
- ☐ ☐ Detergents ________________
- ☐ ☐ Other _____________________

Muscles and Joints

C P comments

- ☐ ☐ Rheumatoid arthritis _______ ____________________________
- ☐ ☐ Osteoarthritis ______________ ____________________________
- ☐ ☐ Osteoporosis ______________
- ☐ ☐ Scoliosis __________________
- ☐ ☐ Broken bones ______________
- ☐ ☐ Spinal Problems ____________ ____________________________
- ☐ ☐ Disk Problems ______________
- ☐ ☐ Lupus _____________________
- ☐ ☐ TMJ Jaw Pain ______________
- ☐ ☐ Spasms, cramps ____________ ____________________________
- ☐ ☐ Sprains, Strains ____________
- ☐ ☐ Tendonitis, Bursitis __________ ____________________________
- ☐ ☐ Stiff or painful joints _________
- ☐ ☐ Weak or sore muscles ________
- ☐ ☐ Neck, shoulder arm pain ____________________________
- ☐ ☐ Low back, hip, leg pain ____________________________
- ☐ ☐ Other ______________________

Nervous System

C P comments

- ☐ ☐ Head injuries concussion ____________________________
- ☐ ☐ Dizziness ringing in the ears___________________________
- ☐ ☐ Loss of memory and confusion ____________________________
- ☐ ☐ Numbness tingling ___________ ____________________________
- ☐ ☐ Sciatica shooting pain ________ ____________________________
- ☐ ☐ Chronic Pain _______________
- ☐ ☐ Depression ________________
- ☐ ☐ Other______________________

Respiratory, Cardiovascular

C P comments

- ☐ ☐ Heart disease ______________ ____________________________
- ☐ ☐ Blood Clots _________________
- ☐ ☐ Stroke ____________________
- ☐ ☐ Lymphadema _______________ ____________________________
- ☐ ☐ High, Low Blood Pressure ____________________________
- ☐ ☐ Irregular Heart Beat ________ ____________________________
- ☐ ☐ Poor Circulation _____________
- ☐ ☐ Swollen Ankles ______________
- ☐ ☐ Varicose Veins ______________
- ☐ ☐ Chest Pain, Shortness of breath ____________________________
- ☐ ☐ Asthma ___________________

Digestive/Elimination System

C P comments

- ☐ ☐ Bowel Dysfunction ________ ____________________________
- ☐ ☐ Gas, Bloating ______________
- ☐ ☐ Bladder, Kidney Dysfunctions ____________________________
- ☐ ☐ Abdominal Pain ____________ ____________________________
- ☐ ☐ Other ____________________

Endocrine System

- ☐ ☐ Thyroid Dysfunctions ____________________________
- ☐ ☐ Diabetes _________________

Reproductive System

- ☐ ☐ Pregnancy ________________ ____________________________
- ☐ ☐ Painful, Emotional Menses ____________________________
- ☐ ☐ Fibro tic Cysts _____________

Cancer/ Tumors

- ☐ ☐ Benign ___________________
- ☐ ☐ Malignant ________________

Habits

- ☐ ☐ Tobacco _________________
- ☐ ☐ Alcohol _________________
- ☐ ☐ Drugs ___________________
- ☐ ☐ Coffee, Soda _____________

Consent for Care

It is my choice to receive massage therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature ____________________________________ Date ____________

Signature of parent or guardian _________________ Date ____________
(If patient is a minor)