



CHIROPRACTIC PARTNERS, S.C.

AUTO AND WORK INJURIES • SPORTS INJURIES • FAMILY PRACTICE • NUTRITION AND WELLNESS CARE • MASSAGE AND PHYSIOTHERAPY

CONFIDENTIAL INFORMATION

Welcome. We want to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your visit, please let us know.

NAME _____ HOME # _____ WORK# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____ PHYSICIAN'S NAME _____

OCCUPATION _____ REFERRED BY: _____

HAVE YOU EVER RECEIVED MASSAGE THERAPY BEFORE? YES NO

REASON FOR THIS VISIT? _____

ARE YOU TAKING ANY MEDICATIONS? _____ DESCRIBE _____

HAVE YOU CONSUMED ALCOHOL IN THE PAST 24 HOURS? YES NO

DO YOU HAVE A HISTORY OF THE FOLLOWING?

- | | | |
|--|--|--|
| <input type="checkbox"/> accident | <input type="checkbox"/> sprains | <input type="checkbox"/> fibromyalgia |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> seizures | <input type="checkbox"/> breast augmentation |
| <input type="checkbox"/> whiplash | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> headaches | <input type="checkbox"/> nervous tension | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> disk problems | <input type="checkbox"/> arthritis, bursitis or gout | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> allergies to oils or perfumes | <input type="checkbox"/> stroke |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> wear contacts or other prosthesis | <input type="checkbox"/> heart attack |
| <input type="checkbox"/> joint ache | <input type="checkbox"/> surgery | <input type="checkbox"/> cancer |
| <input type="checkbox"/> decreased range of motion | | <input type="checkbox"/> colitis |
| <input type="checkbox"/> broken bones | | <input type="checkbox"/> HIV |

Please indicate if your consumption is:

	None	Light	Moderate	Heavy
salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU HAVE ANY OF THE FOLLOWING TODAY:

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> sunburn | <input type="checkbox"/> open cuts, bruises, burns |
| <input type="checkbox"/> inflammation | <input type="checkbox"/> irritated skin rash |
| <input type="checkbox"/> severe pain | <input type="checkbox"/> poison ivy |

ADDITIONAL INFORMATION OR COMMENTS:

PLEASE READ AND SIGN BELOW:

- I understand that this massage is not a replacement for medical or chiropractic care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours**

DATE: _____ SIGNATURE: _____

PLEASE INDICATE WITH AN (X), THE PLACES YOU ARE FEELING DISCOMFORT

