STEVENS CHIROPRACTIC & WELLNESS CENTER

First Name _____ Date of birth _____

Last Name _____ Referred by _____

Email Address _____ Mobile Phone # _____

Home Phone # _____

Street Address _____ City _____

State _____ Zip Code _____

Emergency contact name _____

Emergency contact relationship _____

Emergency phone # _____

How would you rate your general health?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Have you had a professional massage before?

- ○ Yes *(Date of last treatment)* _____
- ○ No

List current medications & the conditions they are treating

List any major accidents or surgeries

Please tell us about any allergies or hypersensitivities

Reason for visit

HEAD NECK

- ○ Headaches / migraines
- ○ Vertigo / dizziness
- ○ Ringing in ears
- ○ Hearing loss
- ○ Vision problems
- ○ Vision loss

RESPIRATORY

- ○ Asthma
- ○ Shortness of breath
- ○ Chronic cough
- ○ Bronchitis
- ○ Emphysema
- ○ Sinusitis
- ○ Frequent colds
- ○ Smoker
- ○ Family history of respiratory difficulties

NERVOUS SYSTEM

- ○ Sensory loss / change
- ○ Numbness / tingling
- ○ Sciatica
- ○ Epilepsy
- ○ Seizures
- ○ Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- ○ Arthritis
- ○ Family history of arthritis
- ○ Osteoporosis
- ○ Tendonitis
- ○ Bursitis
- ○ Jaw pain (TMJ)
- ○ Pins / plates / wires / artificial joint

REPRODUCTIVE

- ○ Pregnant
- ○ Given birth
- ○ Gynecological problems

CARDIOVASCULAR

- ○ High blood pressure
- ○ Low blood pressure
- ○ Heart attack
- ○ Stroke
- ○ Heart disease
- ○ Poor circulation
- ○ Phlebitis / varicose veins
- ○ Pacemaker
- ○ Hemophilia
- ○ Chronic congestive heart failure
- ○ Family history of cardiovascular problems

SKIN & INFECTIONS

- ○ Hepatitis
- ○ HIV / AIDS
- ○ Herpes
- ○ Tuberculosis
- ○ Lyme disease
- ○ Infectious skin conditions

OTHER CONDITIONS

- ○ Cancer
- ○ Diabetes
- ○ Unexplained weight loss
- ○ Digestive conditions
- ○ Fibromyalgia
- ○ Chronic fatigue syndrome
- ○ Depression
- ○ Anxiety
- ○ Psychiatric disorder
- ○ Other conditions _____

_____

_____

_____

STEVENS CHIROPRACTIC &WELLNESS CENTER

I, _____, understand that massage therapy provided by the massage therapist is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer positive experience of touch.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my chiropractor for any conditions I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of the massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the massage therapist so the treatment can be adjusted.

I have read and understand the therapist's policies and agree to abide by them.

_____ _____

Signature Witness Signature

_____ _____

Date Date

MASSAGE POLICY

(CANCELLATION/NO SHOW)

THIS OFFICE REQUIRES 24 HOURS NOTICE IF YOU SHOULD NEED TO CANCEL OR RESCHEDULE YOUR MASSAGE APPOINTMENT. BY SIGNING THIS FORM, YOU ARE AGREEING TO PAY $ 38.00 IF THIS IS NOT DONE. THIS FEE CANNOT BE BILLED TO YOUR INSURANCE.
THANK YOU FOR UNDERSTANDING.

_____ _____

Patient Signature Date Signed

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