First Choice Family Chiropractic

Medical Massage Therapy
New Patient Registration

Name: ______________________________ Home Phone: (____)____________ Today's Date: ___/___/___

Address: ____________________________Work Phone: (____) ___________ Occupation: _____________

City: ___________________ State: _____ Zip: ___________ Email:___________________________

Date of Birth: _____/_____/_____________Gender: M ___F___

Are you presently treated by: MD? ____ Chiro? ____ PT? ____ Acup? _____Other____________________

Physician: _______________________ Location: __________________ Phone #: (____)_________________

HMO/Insurance Provider: _____________________________ Member ID#: _________________________

Present Medications: ____

Recent Surgery or Injury: ____

In Case of Emergency: ____Phone: (____)___________________

Referred By: ( ) Friend/Co-worker ________________________ ( ) Dr./PT_________________________

( ) Newspaper________________ ( ) Yellow Pages ( ) Other__________________________

Please check the appropriate box for any of the following that you have or have had previously.

GENERAL MEDICAL
- ( ) Food Allergies
- ( ) Skin Allergies
- ( ) Cancer
- ( ) Chronic Fatigue
- ( ) Headaches
- ( ) Depression / Anxiety
- ( ) Diabetes
- ( ) Asthma
- ( ) Difficulty Sleeping
- ( ) Nerve Pain
- ( ) Numbness

GASTRO-INTESTINAL
- ( ) Constipation
- ( ) Diarrhea
- ( ) Nausea
- ( ) Stomach Pain
- ( ) Ulcers

EYES / EARS / THROAT
- ( ) Cold (current)
- ( ) Deafness
- ( ) Enlarged Glands
- ( ) Hay Fever / Allergies

MUSCULOSKELETAL
- ( ) Arthritis
- ( ) Back Pain – Lower
- ( ) Back Pain – Middle
- ( ) Back Pain – Upper
- ( ) Bursitis
- ( ) Gout
- ( ) Joint Swelling
- ( ) Joint Replacement
- ( ) Pain between shoulders
- ( ) Multiple Sclerosis

RESPIRATORY
- ( ) Chest Pain
- ( ) Difficulty Breathing
- ( ) Chronic Cough
- ( ) Tuberculosis

SKIN
- ( ) Acne
- ( ) Bruise Easily
- ( ) Eczema / Psoriasis
- ( ) Open Wounds / Sores
- ( ) Rashes
- ( ) Skin Cancer
- ( ) Other __________________

PAIN OR NUMBNESS IN:
- ( ) Arms
- ( ) Elbows
- ( ) Wrists
- ( ) Hands
- ( ) Neck
- ( ) Shoulders
- ( ) Hips
- ( ) Tailbone
- ( ) Legs
- ( ) Calves
- ( ) Knees
- ( ) Ankles
- ( ) Feet

CARDIAC / CIRCULATORY

( ) Aneurysm
( ) Varicose Veins
( ) Hardening of the Arteries
( ) Heart Disease
( ) High Blood Pressure
( ) Poor Circulation
( ) Stroke

WOMEN ONLY

( ) Are you pregnant? Y / N
If yes Due Date_______
( ) Gynecological Problems
( ) Menstrual Problems
( ) PMS

Comments / Additional Information:

Previous Massage Therapy? Y / N Date of last treatment?
____

What level of massage pressure do you prefer? ( ) Light ( ) Medium ( ) Strong

Are you in pain now? Y__ N___ Describe:
____

Comments:

LIFESTYLE:
Home Life: ( ) Stressful much of the time ( ) Stressful sometimes ( ) Not stressful
Work Life: ( ) Stressful much of the time ( ) Stressful sometimes ( ) Not stressful
Exercise: ( ) Frequently ( ) Regularly ( ) Sometimes ( ) Not usually
Eat Well: ( ) Always ( ) Mostly ( ) Usually ( ) Not usually
Sleep Well: ( ) Always ( ) Mostly ( ) Usually ( ) Not usually

Please take a moment to read the following information and sign where indicated:

I understand that the massage therapy I receive is for the purpose of stress reduction, relief from muscular tension or spasm, or for improving circulation. I further understand that a massage therapist is not qualified to diagnose illness, disease, or any other medical disorder and does not perform high velocity joint manipulations. I understand that massage therapy is contraindicated for some medical conditions and failure to disclose such conditions could result in injury or increase symptoms for which the therapist will not be held liable. I am responsible for consulting a qualified physician for any ailment that I may have. A referral from your primary care provider may be required prior to the massage service. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so.

CANCELLATIONS and MISSED APPOINTMENTS:

Cancelations must be made 24 hours prior to time of scheduled appointment. If appointment is missed or notice has not been given 24 hours prior to the time of appointment, a $30.00 charge will be billed to the account.

I agree to pay for all services at the time they are rendered.

Patient Signature ____
Date ______________________

Practitioner Signature ____
Date _______________________

***Consent to treatment of minor*:**

By my signature below, I hereby authorize _____________________
To administer massage therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian ________________________________
Date________________________