SPINECARE
CHIROPRACTIC CENTER

MASSAGE INTAKE FORM

_____

PATIENT'S PREFERED NAME

_____

DATE COMPLETED

Patient Information

Name: _____ DOB: ____/____/_____ Gender: M F

Home Address: _____ Home Phone:_____

City, State, Zip: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

□ I do not want to receive emails with clinic/health related information from SpineCare Chiropractic

Social Security: _____ Marital Status: S M D W S

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Children's Name(s): _____

How were you referred to this office? _____

Purpose For This Visit

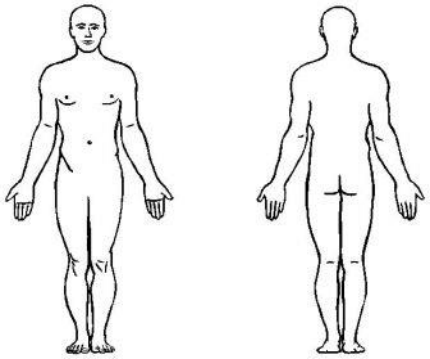
1) _____ Onset:___/___/___ How did symptom start? _____

Frequency: Constant Frequent Intermittent Occasional **Severity**: mild 1 2 3 4 5 6 7 8 9 10 severe

2)_____ __Onset:___/___/___ How did symptom start? _____

Frequency: Constant Frequent Intermittent Occasional **Severity**: mild 1 2 3 4 5 6 7 8 9 10 severe

***If your symptoms are the result of an auto accident or work related injury, please let the front desk staff know.**



Please indicate your pain on the diagram:

A = Ache	G = Stabbing	N = Numbness
B = Burning	M = Spasms	T = Tingling
S = Stiffness	O = Other	

Are they getting worse? □Yes □No **Do they interfere with**: □Work □ Sleep □ Hobbies □ Daily routine

Explain _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? Yes No If yes, explain: _____

Have you experienced these symptoms before? Yes No

If yes, explain: _____

Have you been treated for this? □Yes □ No When were your last treated? _____

What treatment was performed? _____

How did you respond? _____

Have you seen a chiropractor before? Yes No Who? _____

Health & Lifestyle

Do you exercise? □ Yes □ No How often? _____ days per week; Other _____

What activities? □ Walking □ Running □ Weight Training □ Cycling □ Yoga □ Pilates Other _____

Do you smoke? □ Yes □ No How much/often? _____

Do you drink alcohol? □ Yes □ No How much/often? _____

Do you drink coffee? □ Yes □ No How much/often? _____

Do you take any supplements? (i.e. vitamins, minerals, herbs)? _____

_____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL The areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span. Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Have you experienced any of these symptoms presently or in the past?
Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Neck Pain
___ Pain in the shoulders/arms/hands
___Numbness/tingling in arms/hands
___ Hearing disturbances
___ Weakness in grip
___ Heaviness
___ Headaches
___ Dizziness
___ Visual disturbances
___ Coldness in hands
___Thyroid conditions
___ Sinusitis
___Allergies/Hay fever
___ Recurrent colds/flus
___ Low Energy/Fatigue
___ TMJ/Pain/Clicking

Please Explain: _____
_____
_____

THORACIC SPINE (UPPER BACK)

Have you experienced any of these symptoms presently or in the past?
Please indicate (N) = Now, (P) = Past, next to all conditions you've experienced or both if applicable.

___ Heart Palpitations
___ Heart Murmurs
___ Tachycardia
___ Heart Attacks/Angina
___ Mid Back Pain
___ Pain in Ribs/Chest
___ Asthma/Wheezing
___ Indigestion/Heart Burn
___Nausea
___ Ulcers
___ Diabetes
___ Reflux

Please Explain: _____
_____
_____

LUMBAR SPINE (LOW BACK)

Have you experienced any of these symptoms presently or in the past?
Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Pain in hips/legs/feet
___ Numbness/tingling in legs/feet
___ Frequent/difficulty urinating
___ Constipation/Diarrhea
___Weakness/injuries in hips/kness/ankles
___ Recurrent bladder infections
___ Muscle cramps in legs/feet
___ Menstrual irregularities/cramping (females)
___ Low back pain
___ Coldness in legs/feet
___ Sexual dysfunction

Please Explain: _____
_____
_____
_____

Other

Please list any health conditions not mentioned: _____
_____
_____

Please list any medications (include name, dose, for what condition, and how long you've been taking it):
_____
_____
_____
_____

Please list any surgeries (include type of surgery and date it was performed): _____
_____
_____
_____
_____

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following (please indicate Y for You, and O for Other than you, or both if applicable):

___ Diabetes
___ Fibromyalgia
___ High Blood Pressure
___ Kidney Disease
___ Liver Disease
___ Herniated Disc
___ Pneumonia
___ Digestive Disorders
___ Thyroid Problems
___ Blood Sugar Problems
___ High Cholesterol
___ Vertigo
___ Circulatory Problems
___ Heart Disease
___ Paralysis
___ Metal Implants
___ Appendectomy
___ Scoliosis
___ Multiple Sclerosis
___ ADD/ADHD
___ Epilepsy/Seizures
___ Other: _____
___ Neurological Problems
___ Stroke
___ Cancer
___ Migraine Headaches
___ Chronic Fatigue
___ Asthma
___ Parkinson's Disease
___ Influenza
___ Eczema/Psoriasis
___ TMJ Dysfunction
___ Lung Disease
___ Heart Murmur
___ Osteoporosis
___ Arthritis
___ Gall Bladder
___ Hernia
___ Anemia
___ Tumors
___ Bronchitis
___ Depression
_____

Women: Are you pregnant? □Yes □ No Are you nursing? □Yes □ No

Women: Are you taking birth control pills? □Yes □No Last Menstrual Period: ___/___/___

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____ Date _____ DOB __ _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **SpineCare Chiropractic Center** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to **SpineCare** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.

- If **SpineCare** contacts me by phone, I give them permission to leave a phone message with a member of my household, on my answering machine or voice mail.

- By signing this form you are giving **SpineCare** permission to use and disclose your protected health information in accordance with the directives listed above, and in accordance with our Notice of Privacy Practices. A copy of this Notice is available per request.

SpineCare Chiropractic Center utilizes an open adjusting approach to treating patients, other patients may be in the room while you are being treated and they may be able to overhear some of your protected health information during the course of care. However if you need to speak with the doctor at any time in private, the doctor will provide a room for these conversations. If you have a problem with the open room treatments please notify the doctor immediately.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this Authorization, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **SpineCare Chiropractic Center**. The written notice must contain the following information: Your name, Social Security number and date of birth; a clear statement of your intent to revoke this AUTHORIZATION; the date of your request, and your signature.
The revocation is not effective until it is received by the Privacy Official.
You have the right to refuse to sign this Authorization. If you refuse to sign this AUTHORIZATION, **SpineCare Chiropractic Center** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THE NOTICE OF PRIVACY PRACTICES HAS BEEN MADE AVAILABLE TO ME.
_____(Patients Initials)

Print Name of Patient _____ Date _____

Signature of Patient _____ Signature of Witness _____

Massage Therapy Informed Consent

The general benefits of massage, possible contraindications, and the treatment procedure have been explained to me. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medication, and that spinal manipulations are not part of massage therapy. I hereby consent for my therapist to treat me with massage therapy including such assessments, examinations, and techniques which may be recommended by my therapist.

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 therapist so that treatment can be adjusted.

We request that you respectfully provide 24 hours notice of cancellation. If you fail to cancel an appointment in less than 24 hours or fail to attend a scheduled appointment you will be charged the regular fee for that appointment. In order to schedule a massage we do require a credit card being placed on file.

If you choose to participate in our auto debit program for massage therapy we require a 3 month minimum commitment. With the autodebit program there will are no refunds and all missed appointments must be made up within 60 days.

I understand the therapist's policies, and agree to abide by them. I understand that at any time I may withdraw my consent and treatment will be stopped.

_____ _____

Patient Name (Print) Date

_____

Signature of Patient/Guardian