CLEAR CHOICE CHIROPRACTIC

Massage Health Intake Form

Name:_____

Street Address:_____

City_____ State_____ Zip_____ Date of Birth _____

Work Phone _____ Home phone _____Cell phone _____

Emergency Contact _____ Phone_____

Employer _____ Phone _____

Occupation_____

Referring Physician:_____ Phone _____

Primary Care Physician:_____ Phone _____

Insurance Company Name:_____

Billing Address:_____

Phone Number:_____ Contact person: _____

Group/Claim Number: _____

What is the reason for your visit today?

_____

Primary Complaint: □Neck □Upper Back □Mid Back □ Lower Back □Shoulder □Wrist □Knee
Secondary Complaint: □Neck □Upper Back □Mid Back □ Lower Back □Shoulder □Wrist □Knee
Tertiary Complaint: □Neck □Upper Back □Mid Back □ Lower Back □Shoulder □Wrist □Knee

Please list any other complaints (not mentioned above):

_____

When did your symptoms appear? Date _____ (if applicable)
□ A few days ago □ A week ago □ Couple weeks ago □ Month ago □ Couple months
□ Within the last year □ 1 year ago □ Years ago

What was the cause of your injury?
□ Auto Accident □ Work Injury □ Bent down □ Fell □ Lifted something heavy □ Slept wrong
□ Sports □ Unknown □ Other (Describe) _____

Rate your intensity of your pain on a scale from ***1*** *(least pain) to* ***10*** *(severe pain)*
Primary Complaint: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Secondary Complaint: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Tertiary Complaint: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Type of pain:
□ Aching □ Burning □ Dull □ Numbness □ Sharp □ Shooting □ Stiffness □ Swelling
□ Throbbing □ Tingling □ Radiating, If yes: Where does it radiate: _____ □ Other _____

How often are you experiencing your pain?
□ Constant (76-100%) □ Frequently (51-75%) □ Occasionally (26-50%) □ Intermittently (0-25%)

Activities or movements that is painful to perform? □ Bending □ Lying Down □ Sitting □ Standing □ Walking □ Other _____

Have you used any of these to treat your symptoms? □ Ice □ Heat □ Medication □ Other

Medical History and Information: *Circle* all that apply to your present health:

Headaches Chronic pain Varicose veins Vision problems Muscle or joint pain Tendonitis

Blood clots Sinus problems Numbness/tingling High/low blood pressure Diabetes Arthritis

Jaw pain/teeth grinding Sprains/strains Fatigue Scoliosis Cancer/tumors Depression

Infectious disease Sleep difficulties Skin problems

Women only: ___Pregnant ___ Painful menstruation ___Endometriosis

Men only: ___ prostrate problems

MASSAGE:

Any Allergies your Massage Therapist should be aware of? _____

What type of pressure do you prefer: □ Relaxation □ Medium □ Firm

Communication preference during a massage: □ No Talking □ Small Talk □ Open to Talking

List all medications/herbs/vitamins and dosage: _____
_____

List physical activities you participate in regularly: _____
_____

List previous major injuries/surgeries: _____
_____

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic): _____

What treatment seems to help the most? _____

What seems to aggravate the condition the most?_____

What is your main activity at work?
____ On phone ____ Sitting ____ Computer Work ____ Driving ____ Walking
___Other (Describe) _____

What do you do to relieve stress?_____

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

I understand I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes partial payment, I am responsible for any balance due under contractual obligations which apply. **I also understand that if I cancel 24 hours in advance of my appointed massage time I am liable to pay full rate for the massage time.**

INITIAL:_____

I will consult my practitioner with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

I also understand that I have the option to receive care at any Clinic or spa whether with Clear Choice Chiropractic, or not. We value you as a patient/client and respect your options.

I give my consent & acknowledgement of the above information and to receive treatment at this facility.

Print Name:_____ Date:_____

Signature _____