PATIENT INFORMATION

A. Name _____ Date _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell# _____ Work # _____ SS# _____

E-mail Address _____ Sex *M F* Marital Status *S M W D* # Children ____

Referred By _____ Insurance Company _____

Employer _____ Job Title _____ Job Description _____

B. Medications: _____

Vitamins: _____

Allergies to Medications: _____

Prev. Chiro. Care: _____ Prev. x-rays: _____

Name of Primary Care Physician: _____

May we send a report to them? Y N Your current weight: _____ Height _____ Shoe size _____

Previous car accidents or falls: _____

Surgeries: _____

Broken bones: _____

Other traumas? _____ Previous Stroke or TIA? _____

Sleeping posture ❑ side ❑ stomach ❑ back **Posture** ❑ good ❑ fair ❑ poor

Current Hobbies, Sports, Activities: _____

Is there a chance that you could be pregnant? Y N

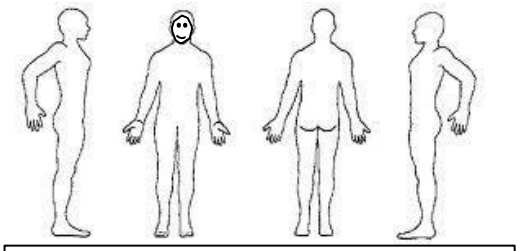
What brings you to the office today? PS-Pain Scale 1-10

1. _____ PS____

2. _____ PS____

3. _____ PS____

4. _____ PS____



Circle on the body any area you're currently having pain

Date First Noticed _____ Ever had it before? Y N

It was caused by _____ Missed work due to this? Y N

What have you done to treat this? _____

Other professionals seen for this? _____

Is this a car or work accident? Y N Date and time of accident _____

Hurts more when: Sitting / Bending / Lifting / Twisting / Riding in car / Working / Sleeping / Standing / House Work / Walking / Straining / Constant / Other: _____

Hurts less when: ❑ OTC meds ❑ Prescription ❑ Rest ❑ Lay down ❑ Sleep ❑ Sit ❑ Stretch ❑ More active ❑ With ice ❑ With heat ❑ Massage ❑ Other _____

Description: ❑ Sharp ❑ Dull ❑ Throb ❑ Radiating ❑ Shooting ❑ Numb ❑ Tingling ❑ Stiff

My goals for my care here: _____

Caffeine	❑ None	❑ Some	❑ Much
Cigarettes	❑ None	❑ Some	❑ Much
Alcohol	❑ None	❑ Some	❑ Much

Energy Level:	No Energy	1	2	3	4	5	6	7	8	9	10	Energetic
Flexibility:	Can't Move	1	2	3	4	5	6	7	8	9	10	Very Flexible
Stress Level:	No Stress	1	2	3	4	5	6	7	8	9	10	Much Stress
Spiritual Interest:	No Interest	1	2	3	4	5	6	7	8	9	10	Very Interested

Overall State
__ Fever __ Chills
__ Fatigue __
__ Loss of appetite
__ Weight loss or gain
__ None
__

Emotional Issues
__ Irritability
__ Depression
__ Poor Sleep
__ Anxiety
__ None
__

Urinary System Issues
__ Frequent urination
__ Urgency
__ Burning
__ Loss of control
__ None
__

Vision Issues
__ Blurred
__ Double
__ None
__

Heart Issues
__ Chest pains
__ Palpitations
__ Fainting
__ None
__

Breathing Issues
__ Coughing
__ Wheezing
__ Shortness of breath
__ Asthma
__

Digestion Issues
__ Nausea __ Vomiting
__ Diarrhea __
__ Less than 2 Bowel
__ Movements Daily
__ None
__

Joint Issues Joint
__ pains Joint
__ weakness
__ Muscle cramps
__ None
__

Skin Issues
__ Rash / Itchiness
__ Dryness
__ Open wounds
__ None
__

Immune System Issues
__ Lymph nodes enlarged
__ Allergies
__ Frequent infections
__ None

Endocrine Issues
__ Diabetes / Low blood sugar
__ Thyroid issues
__ Weak spells, tiredness
__ Shakiness before meals
__ None

Neurological Issues
__ Seizures
__ Headaches
__ Tingling
__ Numbness
__ Poor coordination
__ Migraines

Circulation Issues
__ Anemia
__ Bleeding
__ Bruising
__ Cold extremities
__ None

Skeletal Issues
__ Osteoporosis
__ Osteopenia
__ Neck pain
__ Back pain
__ None

Do you:
__ Eat only few vegetables?
__ Eat fast foods?

Family History of:
__ Arthritis
__ High Cholesterol
__ High Blood Pressure
__ Diabetes
__ Heart Disease
__ Cancer

INITIALS: _____

Delta Chiropractic Center
6130 W Saginaw Hwy
Lansing, MI 48917

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

Name: _____ Phone #: _____ Cell #: _____
Address: _____ City: _____ St: ___ Zip: _____
Date of Birth: _____ Age: _____ M: __ F: __ Marital Status: _____
Have you ever received massage therapy before? Yes _____ No _____
Are you taking medication? _____ Describe: _____
_____

Have you consumed alcohol in the last 24 hours? Yes _____ No _____

Do you have a history of the following?

__Accident
__Neck Pain
__Disc problem
__Headaches
__Seizures
__HIV
__Allergies to oils, perfumes
__Sprains
__Heart Attack
__ Whiplash
__ Nervous tension
__ Diabetes
__Abdominal pain
__Arthritis/Bursitis or Gout
__ Joint ache
__ Low back pain
__Broken bones
__Stroke
__ Decreased range of motion
__ Wear contacts
__ Wear prosthesis
__ Surgery
__ Varicose veins
__ High blood pressure
__ Mid back pain
__ Breast augmentation

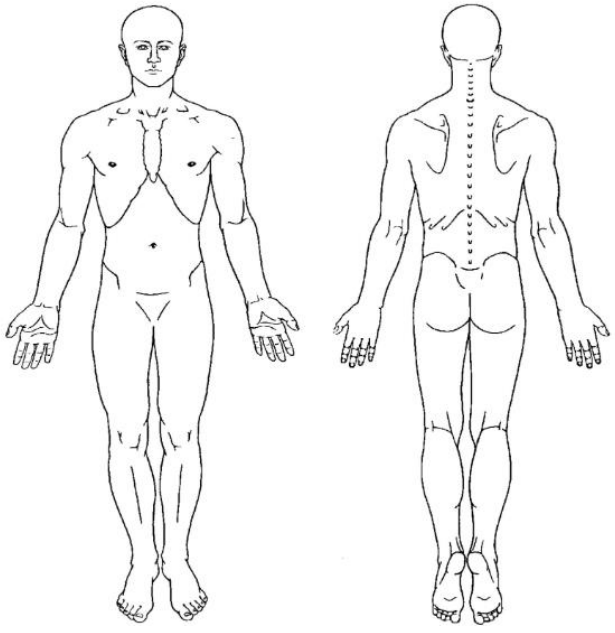
Please indicate consumption level

	None	Light	Mod.	Heavy
Salt	___	___	___	___
Sugar	___	___	___	___
Caffeine	___	___	___	___
Tobacco	___	___	___	___
Exercise	___	___	___	___
Water	___	___	___	___
Alcohol	___	___	___	___

Do you have any of the following today?

__Sunburn
__Inflammation
__Severe pain
__Headache
__ Open cuts, bruises, burns
__Irritated skin rash
__Poison ivy
__Cold/Flu
Other _____

Please circle the places you are feeling discomfort



Preferred conversation level during massage:
___ Minimal
___ No preference

Please read the following and sign below

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

Signature: _____ Date: _____

DELTA CHIROPRACTIC CENTER

Massage Policy

Please remember that your appointment time is reserved especially for you. We understand that unanticipated events happen occasionally in everyone's life. However, in our desire to be fair to all of our clients and out of consideration for our Massage Therapist's time, we have adopted the following **mandatory 24 hour notice policies:**

- **All same day cancellations** will be charged 100 % of the full session price.
- **No shows** will be charged 100 % of the full session price.
- **Late arrivals** will be charged 100 % of the full session price. However, you will only receive what time remains in your scheduled appointment.
- In the same way, if you have a gift certificate, the missed session will be forfeited.
- Appointments that are **rescheduled** 24 hours in advance are not subject to our cancellation policy. *However, you must **speak to** one of our front desk assistants (A voicemail message does not count).*
- We ask that all clients arrive at least 10 minutes prior to your scheduled appointment time.
- Due to the sensitivity of pregnancy in the early stages, it is recommended that massage is held until after three months.

Print Name_____

Signature _____