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

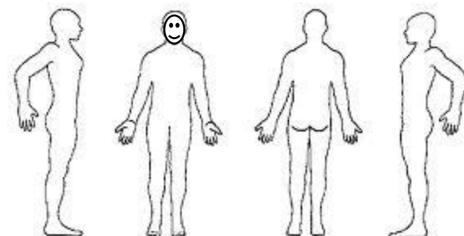
What brings you to the office today? PS-Pain Scale 1-10

1. ______________________________ PS____

2. ______________________________ PS____

3. ______________________________ PS____

4. ______________________________ PS____



Right	Front	Back	Left

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?

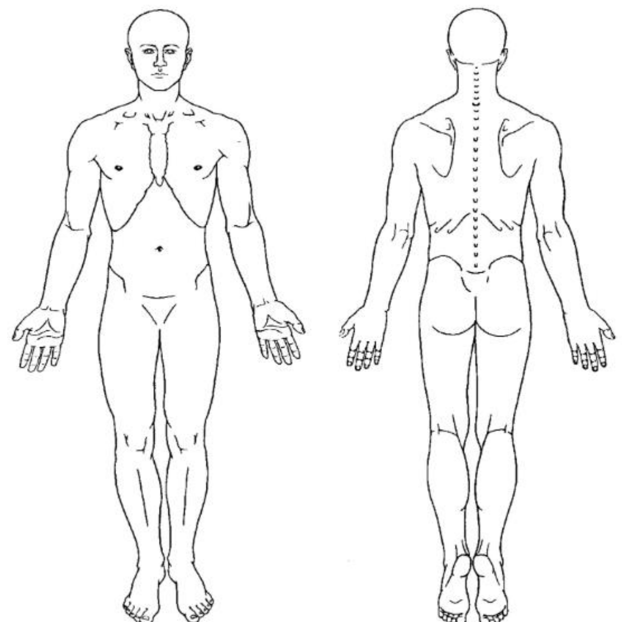
__Sunburn
__Inflammation
__Severe pain
__Headache
__ Open cuts, bruises, burns
__Irritated skin rash
__Poison ivy
__Cold/Flu
Other ____________________________________

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.**

Please circle the places you are feeling discomfort



Signature: ___________________________________ Date: ____________