

**COMPLETE CHIROPRACTIC & BODYWORK THERAPIES
PATIENT/CLIENT UPDATE FORM**

Date _____ Referral Source _____

Name _____
Last First Middle Name I prefer to be called

Address _____
City State Zip

Phone (____) _____ (____) _____ (____) _____
Home Work Cell/Pager

Email _____ Male _____ Female _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Marital Status: S M W D Partner

Emergency Contact _____
Name Phone # Relationship

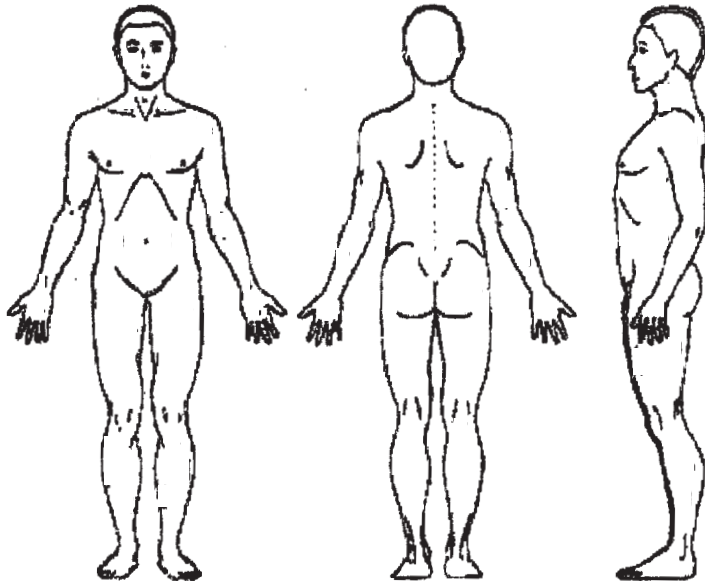
The best phone number to use to contact me or leave a message is (____) _____.

**COMPLETE CHIROPRACTIC & BODYWORK THERAPIES
PATIENT/CLIENT COMPLAINT/SYMPTOM FORM**

Date _____ Name: _____

Height _____ Weight _____

Using the symbols below, mark on the pictures where you feel pain.



Numbness	===
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	///
Pins, Needles	+++
Other _____	^^^

Please state your chief complaints:

How long have you had the symptoms?

How did the condition begin?

How long did the symptoms last?

What makes it worse?

What makes it better?

How would you describe your pain on a scale of 1 to 10?

Circle one:

(0 is none - 10 severe) 1 2 3 4 5 6 7 8 9 10

Name: _____ Date: _____

Previous treatment for this complaint (include any doctors names, dates treated, test results, or home remedies: _____

(If you need more room; please write on back of sheet)

<i>X-rays, MRI's or CT's</i>	<i>Where Taken</i>	<i>Date</i>

Past Surgical History

<i>Surgery</i>	<i>Year</i>

Hospitalizations (other than surgery)

<i>Reason</i>	<i>Year</i>

Accidents/Injuries

<i>Accident/Injury</i>	<i>Year</i>

Current medications/supplements _____

Known allergies to medications/supplements _____

Exercise, type and frequency: _____

Describe your typical diet for

Breakfast: _____

Lunch: _____

Dinner: _____

How much of the following do you consume daily?

Water: _____ Milk: _____ Soda: _____ Coffee _____

Cigarettes: _____ Sweets: _____ Alcohol: _____ Tea _____

Abdominal gas frequently? _____ #of bowel movements daily? _____

List any recent travel: _____

Age of mattress: _____ Regular: _____ Waterbed _____ Fouton: _____ Sleep Position _____

Do you like your job? _____ How do you relieve stress? _____

Spiritual/Religious affiliation/Meditation/Prayer _____

List hobbies: _____

With whom do you live? _____

Estimate the stress in your life: _____ None _____ Mild _____ Moderate _____ Great

Date of last physical exam? _____

Have you ever had a professional massage, Polarity Therapy or craniosacral therapy? _____

Are you currently in psychotherapy? _____

Name _____ Date _____

Please CHECK conditions that apply and CIRCLE to specify further as necessary:

Past	Current	SPECIFY
		Abdominal
		Allergies
		Anxiety
		Arthritis, osteo or rheumatoid
		Asthma
		Bleeding Disorder
		Blood Clots
		Blood Pressure high or low
		Cancer
		Chest Pain
		Chicken Pox/Measles/Mononucleosis
		Cough
		Dental/TMJ
		Depression
		Diabetes
		Digestive Disorder
		Dizziness/Fainting spells
		Ear Disorders/Hearing loss
		Eye Disorders
		Fibromyalgia/Chronic Fatigue
		Genetic Disease
		Gout
		Headaches/Migraines
		Heart Disorder
		Hepatitis
		Hernia
		Kidney Disorder
		Leg cramps
		Low blood sugar
		Lung Disorder
		Lupus
		Malaria
		Nausea/vomiting
		Nose problems/Smell
		Polio, Rheumatic Fever, Scarlet Fever
		Seizures
		Sinus Problems
		Skin Disease
		Spinal problems
		Stroke
		Sudden weight loss/gain
		Thyroid Disease
		Ulcers
		Varicose Veins
		Venereal Disease
		Measles
		Mononucleosis
		Rheumatic Fever
		Scarlet Fever

Name _____ Date _____

Women Only

Men Only

Past	Current	Problems with Breasts	Past	Current	Prostate Problems
		Vaginal Itch/Discharge			Impotence
		Painful Intercourse			Swollen or Painful Testicle
		Take Birth Control Pills			Discharge
		Irregular Cycles/Bleeding			
		Hot Flashes			
		Difficulty Conceiving			
		Age of First Period			
		# of Pregnancies			
		# of Miscarriages			
		# of Abortions			
		Passed Menopause at Age			
		Date/Onset of last period:			
		# of Days between cycles:			

Family History:

Relationship	Age, if Living	Age, at Death	State Health Problems or Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____
Grandfather	_____	_____	_____
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Grandmother	_____	_____	_____

MASSAGE THERAPY WAIVER

I understand that the massage, Polarity and craniosacral therapist (herein called practitioner) does not diagnose illness, disease or any other physical or mental disorder. They do not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. I also understand that massage, Polarity and craniosacral therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a practitioner must be aware of existing physical conditions, I have stated all my known medical conditions and will keep the practitioner updated on my physical health.

Client signature _____ Date _____

CANCELLATION POLICY

- 1) We find it necessary to maintain a strict cancellation policy because of the length of time that we spend with each client, (one hour) and the demands on our schedule. We must do this in order to keep the practice financially viable and to utilize time efficiently.
- 2) **24 hours notice is required for cancellations.** If 24 hour notice is not given, you will be billed for the full amount of the session. If less than 24 hour notice is given, every effort by our staff will be made to fill the appointment from the Waiting List. If it cannot be filled, you will be charged. We cannot bill insurance for missed appointments; therefore, you will be responsible for the payment.
- 3) Exceptions will be made in cases of emergency or illnesses after the approval of the practitioner.
- 4) In return we promise to give you the same amount of notice if we need to cancel and to be on time with appointments. We also promise to give you our full attention during your session.

I understand and agree to comply with the above policy.

Your Name

Date