

Today's date: _____

Who are you?

Patient's name: _____
 Address: _____
 City, state & zip: _____
 Home phone: _____ Cell: _____
 Birth date: _____ Age: _____
 E-mail address: _____

Who do we contact in case of an emergency?

Contact: _____ Phone: _____
 Where would you prefer to be contacted? _____

Occupation?

Employer: _____ Phone: _____

Whom may we thank for referring you: _____

I will be paying by: Cash Check Credit Card (Visa/Disc/MC/AmEx)

Would you like to receive our e-mail newsletter? Yes No

Do you experience any of these health problems?

- Headaches Pulled muscles Car accident Sinus pain/allergies
- Sleeping problems Stressed shoulders Leg & hip pain Scoliosis
- Emotional stress Wrist or joint pain Neck pain Stiffness
- Numbness Work injury Lower back pain Stomach/digestive trouble
- Mid-back pain Loss of energy Lack of exercise Frequent colds/flu

Current health problems: _____

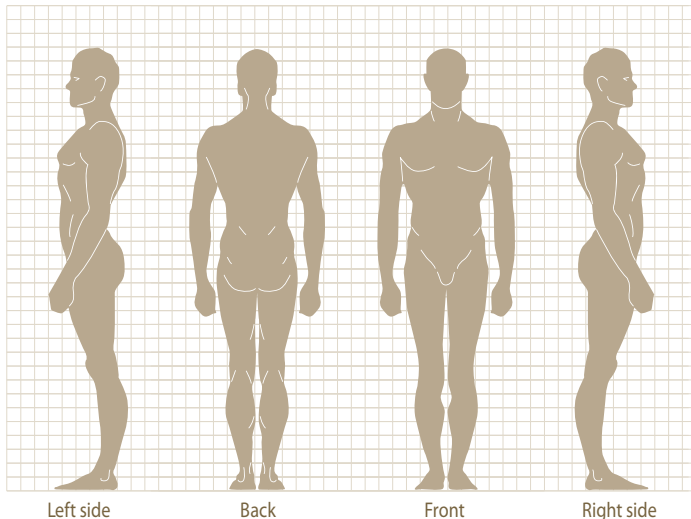
Currently taking medications: _____

Past surgeries: _____

Do these conditions interrupt...

- Career Sleep pattern Ability to exercise Family life Social life

Where are your problem areas?



What methods have you tested?

- Chiropractic Exercise Physical therapy Prescription drugs Nothing

What are your goals for today's massage?

Signature of Agreement

I understand and agree that health insurance is an agreement between the carrier and myself. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered to me will be immediately due and payable. I acknowledge that if I miss an appointment, I will be charged a \$60 missed visit fee.

Signature: _____ Date: _____

Acknowledgement of HIPPA Privacy Act

My signature acknowledges I have read and understand the HIPPA Act.

Signature: _____ Date: _____

Personal representative name printed: _____

Personal representative signature: _____

Relationship to patient: _____ Date: _____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Insurance, your health information on this form may be shared with Medicare/Insurance. Your health information which Insurance sees will be confidential.