

**MESSAGE PATIENT INFORMATION**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 SS# \_\_\_\_\_ Sex:  Male  Female  
 Date of birth \_\_\_\_\_ Age \_\_\_\_\_  
 Marital status: Single Married Divorced Separated Widow  
 Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_  
 Do you have kids?  Yes  No: # of children \_\_\_\_\_  
 Name of family doctor \_\_\_\_\_  
 May we contact them regarding your health?  Yes  No  
 How did you hear about this office? \_\_\_\_\_  
 \_\_\_\_\_

**FINANCIAL POLICY**

**NOTICE TO OUR NEW PATIENTS:**

It is the policy of this office for patients to make payment (cash payments, co-payments, etc.) for services rendered **prior to each visit**. Other payment arrangements (ie. payment plans, etc) must be specifically discussed and/or approved by this office prior to treatment initiation. Deductible payments will be billed on receipt of insurance EOB. See financial policy for further details.

Initials: \_\_\_\_\_

**NOTES / COMMENTS**

Most insurance companies do not have coverage for massage. Please let us know if your insurance carrier has coverage for massage prior to your treatment. In any case, you will be financially responsible for your massage treatments according to our financial policy.

**PHONE NUMBERS, E-MAIL, & EMERGENCY CONTACT**

Home #: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_  
 May we leave a message / voicemail at the above contact numbers?  Yes  No  
 E-Mail Address: \_\_\_\_\_ May we contact you by e-mail? \_\_\_\_\_  
 Would you be interested in receiving an e-mail health newsletter?  Yes  No If yes, please initial: \_\_\_\_\_

***Emergency Contact Information***

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Best contact phone #: \_\_\_\_\_  
 Additional information: \_\_\_\_\_

Have you ever had massage?  Yes  No If yes, when was the last treatment: \_\_\_\_\_  
 Have you ever had massage for this condition?  Yes  No If yes, when was the last treatment: \_\_\_\_\_  
 Have you ever had a bad reaction to massage?  Yes  No Explain: \_\_\_\_\_  
 Do you have any bleeding disorders?  Yes  No Explain: \_\_\_\_\_  
 Are you on any blood thinners (Coumadin)?  Yes  No What medicine: \_\_\_\_\_  
 Have you ever been diagnosed with congestive heart failure (CHF)?  Yes  No  
 Do you currently or have you ever had an infectious disease?  Yes  No If yes, explain:  
 Are you currently pregnant?  Yes  No  
 Are you presently trying to get pregnant?  Yes  No

\_\_\_\_\_  
 Signature of Patient/Parent/Guardian/POA Date Reviewed by: \_\_\_\_\_

PATIENT NAME:

**CURRENT COMPLAINT(S) / CONDITION(S)**

What conditions do you want treated with massage? Reasons for your visit:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

How and when did your problem start? \_\_\_\_\_

Rate your discomfort level today, on a scale from 0 (no pain) to 10 (the worst imaginable): \_\_\_\_\_

Is your condition?  Constant (100% of day)  Frequent (75% of day)  Occasional (50% of day)  Intermittent (25% of day)

Describe the condition:

Is your condition?  Getting better  Staying the same  Getting worse  Unknown

Does it interfere with?  Work  Sleep  Recreation  Daily Activity  Nothing  Other \_\_\_\_\_

What other activities does it interfere with?

What tests have you had?  X-rays  MRI  EMG  Ultrasound  Lab work  Other: \_\_\_\_\_

What treatment have you had?  MD  PT  Medication  Injections  Surgery  Other \_\_\_\_\_

Has the treatment helped?  Yes  No If yes, explain: \_\_\_\_\_

Do you have:  Depression  Anxiety  Nervousness  Panic attacks  Bad temper  Poor memory  Poor concentration  
 Other Stress  Explain:

What are your goals with the treatment?

**DATES OF MOST RECENT EXAMS**

Spinal X-ray \_\_\_\_\_ Physical exam \_\_\_\_\_ Chest X-ray \_\_\_\_\_ Blood work \_\_\_\_\_ Other \_\_\_\_\_

**LIST ALL PREVIOUS INJURIES, HOSPITALIZATIONS, AND/OR SURGERIES**

Injuries/Falls: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Fractures: \_\_\_\_\_

Other hospitalizations or information: \_\_\_\_\_

**FOR FEMALES ONLY**

Do you use birth control:  Yes  No | Are you pregnant:  Yes  No | Due Date: \_\_\_\_\_ | Date of last period: \_\_\_\_\_

\*\* By selecting no, I hereby notify all concerned that I neither suspect nor know positively at this time that I may be or am pregnant. Initials \_\_\_\_\_

**Marion Chiropractic Clinic**  
1069 Delaware Ave. Suite 201, Marion, Ohio 43302

**PATIENT NAME:** \_\_\_\_\_

**SOCIAL HISTORY**

<b>Exercise Activity</b> <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous	<b>Use of Alcohol</b> <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Daily _____ drinks per week	<b>Use of Tobacco</b> <input type="checkbox"/> Never <input type="checkbox"/> Previously, but quit <input type="checkbox"/> Currently _____ Packs per day _____ # of years	<b>Work Activity</b> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light labor <input type="checkbox"/> Heavy labor <input type="checkbox"/> Other	<b>Sleep Habits</b> <input type="checkbox"/> 0-2 hrs/night <input type="checkbox"/> 2-4 hrs/night <input type="checkbox"/> 4-6 hrs/night <input type="checkbox"/> 6-8 hrs/night <input type="checkbox"/> more than 8 hrs/night
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**PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS please check  any that apply to you**

<b>Constitutional</b> <input type="checkbox"/> Bad general health <input type="checkbox"/> Recent weight change <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches  <b>Eyes</b> <input type="checkbox"/> Eye disease/injury <input type="checkbox"/> Glasses or contact lens <input type="checkbox"/> Blurred / double vision  <b>Ear, Nose, Throat</b> <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Vertigo <input type="checkbox"/> Sinus problems <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sore throat / voice change <input type="checkbox"/> Swollen glands  <b>Neurological</b> <input type="checkbox"/> Seizures or Epilepsy <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Stroke <input type="checkbox"/> Multiple Sclerosis	<b>Musculoskeletal</b> <input type="checkbox"/> Joint Pain / Stiffness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Fibromyalgia  <b>Cardiovascular</b> <input type="checkbox"/> Chest pain / Palpitations <input type="checkbox"/> Dizziness / Fainting <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Swelling in hands / feet <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart attack <input type="checkbox"/> Congestive heart failure  <b>Gastrointestinal</b> <input type="checkbox"/> Heartburn / Belching <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Blood in stools <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Liver problems <input type="checkbox"/> Ulcers	<b>Genito-urinary</b> <input type="checkbox"/> Pain / Difficulty urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney problems  <b>Respiratory</b> <input type="checkbox"/> Cough / excessive mucus <input type="checkbox"/> Congestion / colds / flu <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia  <b>Psychiatric</b> <input type="checkbox"/> Anxiety / Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Memory loss  <b>Hematologic/Lymphatic</b> <input type="checkbox"/> Slow to heal after cuts <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Anemia <input type="checkbox"/> Enlarged glands	<b>Endocrine</b> <input type="checkbox"/> Excessive thirst / urination <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Skin becoming drier <input type="checkbox"/> Diabetes (Type I / Type II) <input type="checkbox"/> Thyroid disorder  <b>Integumentary (skin, breast)</b> <input type="checkbox"/> Rash / Sores / Hives <input type="checkbox"/> Lesions <input type="checkbox"/> Breast pain or lump <input type="checkbox"/> Dermatitis/Eczema/dry skin  <b>Allergic/Immunologic</b> <input type="checkbox"/> Food allergies <input type="checkbox"/> Airborne allergies <input type="checkbox"/> Systemic Lupus <input type="checkbox"/> Cancer <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Other (see below)  Other: Alcoholism Infertility Menstrual disorders Insomnia Anxiety / depression
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**FAMILY HISTORY**

	Living		Rheumatoid Arthritis		Cancer		Diabetes		Heart, Lung, or Hypertension		Neck, Back, or Disc problems	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brothers/Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICATIONS / TAKEN FOR: SUPPLEMENTS/VITAMINS/HERBS ALLERGIES (Meds, seasonal, etc.)**

1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

Signature of Patient/ Parent of Minor/Guardian \_\_\_\_\_

Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_

\*\*To the best of my knowledge, the questions on these forms have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Marion Chiropractic Clinic of any changes in my personal information, insurance changes, or medical status in a timely manner. Initials: \_\_\_\_\_