New Patient Information

NAME:_______________________________________MALE___FEMALE___ DATE:_________________
(PLEASE PRINT)

ADDRESS:____

CITY:____ STATE:_______ ZIP:__________

PHONE - HOME:_____________________WORK:__________________CELL:_____________________

EMAIL ADDRESS: ____

DATE OF BIRTH:________________________ (AGE):______ HEIGHT_________ WEIGHT__________

EMPLOYER:__________________________________OCCUPATION:____________________________

EMPLOYER ADDRESS:____ PHONE:_______________

(CIRCLE ONE): SINGLE WIDOWED DIVORCED HAVE A SPOUSE or PARTNER

NAME OF SPOUSE OR PARTNER:______________________ REFERRED BY:___________________

EMERGENCY CONTACT: _______________________ PHONE________________________________

Describe the reason you have come here and the symptoms you are experiencing:____________________

____

____

Date of injury or onset of illness: ____

What makes the problem worse: ____

What makes the problem better: ____

What other treatments have you received for this problem: _______________________________________

____

If accident, list type and explain: ____

____

List any allergies that you have: ____

Have you had any serious injuries or diseases? Explain:____

____

____

List and date surgeries/hospitalizations: ____

____

____

List other medical condition (s) and medications you are taking: __________________________________

____

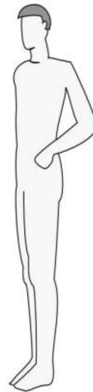
Additional
Comments:____

Manual Therapy Intake Form

Do You Have Any of the Following? (Check All That Apply)

☐ AIDS/HIV	☐ Anemia	☐ Digestive Problems	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Mental Illnesses
☐ Cancer	☐ Osteoporosis	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy or Seizures	☐ Eyes Infection	☐ Urinary Infection
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Migraine Headache
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pregnancy
☐ Stroke	☐ Contagious diseases	☐ Tuberculosis	☐ Dentures
☐ Heart Problems	☐ Liver Problems	☐ Pneumonia	☐ Contact lenses

Mark Areas of Discomfort



Current duration of pain: ☐ intermittent ☐ Constant ☐ With certain motions

Current level of pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

______________________________ Signature

________________________ Date

PATIENT RELEASE AND CONSENT TO TREATMENT

I understand that the manual therapy I receive should not be construed as a substitute for medical examination, diagnosis, or treatment that I should see a physician. I realize that the particular therapeutic outcomes of these treatments cannot be predicted with certainty and no guarantee or promise is made for cure of any specific disease or disorder. I acknowledge that healing may occur with my own natural healing ability and am solely responsible to seek my own medical treatment and care. I affirm that I have stated all my known medical conditions honestly and agree to keep the therapist updated as to any changes in my medical profile. I hereby release and hold harmless of liability for any injury or aggravation of any health problems resulting by my own cause against the therapist.

Payment is required at the time of service and you are responsible for all fees.

Please provide 48 hours cancellation notice if you are unable to keep your appointment.
If we are not notified 48 hours in advance, **we will charge $50 for your missed appointment**.

MY SIGNATURE CONFIRMS THAT I AM AWARE OF AND AGREE TO THE ABOVE.

SIGNATURE: ____DATE:_________________

****

IF THE PATIENT IS UNDER 18, PLEASE COMPLETE THE FOLLOWING:

NAME OF LEGAL PARENTS OR GUARDIAN:____

EMPLOYERS OF PARENTS/GUARDIAN: __________________ OCCUPATION: ________________________

EMPLOYER ADDRESS: ___________________________________ PHONE: ___________________________