HANOVER CHIROPRACTIC & MASSAGE THERAPY

Patient Intake Form

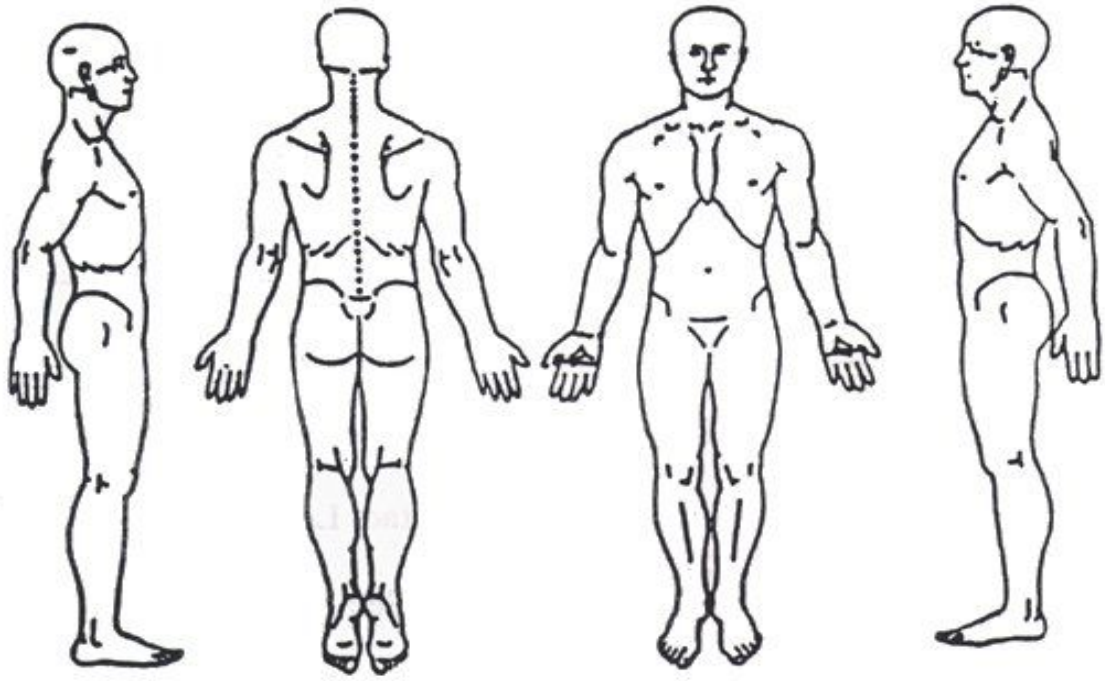
Name _____ Date of Birth_____

Address _____ Phone # _____

Occupation _____ Email _____

Emergency Contact _____ Relationship _____ Phone _____

PLEASE CIRCLE ANY AREAS OF DISCOMFORT



What are your goals for this treatment session?

( )Relaxation ( )Stress ( )Pain ( )Injury ( )Overall Wellness ( )Other

Comments:_____

What is your PRIMARY complaint today? _____

_____

Have you had a professional massage before? No Yes ~~Last Visit:~~ _____

Are you currently pregnant? Yes No

If yes, how far long? _____ Any high risk factors? _____

Please check any CONDITIONS you currently have or had in past 5 years

( ) Motor Vehicle Accident
( ) Work or Sport Injury
( ) Surgery
( ) Medical Implants
( ) Migraines / Headaches
( ) Diabetes
( ) Cancer
( ) Allergies Mild / Severe
( ) Cardiovascular condition (ie: heart disease, high blood pressure)
( ) Respiratory condition (ie: asthma, bronchitis)
( ) Neurological condition (ie: MS, epilepsy, sensory loss)
( ) Mental Health condition (ie: depression, anxiety)
( ) Skin condition (ie: eczema, psoriasis, rash)
( ) Bone or Joint condition (ie: arthritis, fracture, osteoporosis)
( ) Digestive condition (ie: Crohns, heart burn, constipation)
( ) Family history of: Arthritis, Cardiovascular Disease, Cancer, Stroke and/or Diabetes

Please list any MEDICATION or SUPPLEMENTS you currently use and for what condition:

_____

_____

_____

What physical activities do you enjoy? _____

How do you relieve stress? _____

CANCELLATION POLICY

If you need to cancel or reschedule your appointment, please allow 24-hour notice prior to your appointment to avoid a cancellation fee. If you fail to comply you will be subject to 100% cost for the service. All invoices must be paid before scheduling any future appointments.

By signing below, you agree to the following:

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

HANOVER
CHIROPRACTIC
& MASSAGE THERAPY

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____