Name____ Birth Date: ___________________

Address ____ City________________________________

State_________________ Zip______________ Phone #_____________________________________

To receive our monthly special offers please write your email: ____

How did you hear about us? **☐Family ______________________________ ☐Friend ______________________________**
☐Co-Worker ___________________________ ☐Insurance Plan ☐Internet/website ☐Yellow Pages ☐Yellow Book
☐Drive by ☐Physician__________________ ☐Sign Other: ____

Have you in the past twelve months had any of the following symptoms?

☐Tense muscles ☐Restless sleeping ☐Tingling in arms and/or legs
☐Digestive problems ☐Neck Pain ☐Shoulder Pain
☐Mid Back Pain ☐Low Back pain

Other body signals you may have:

☐Allergies/sinusitis ☐Colds and flu ☐Loss of concentration
☐Headaches ☐Menstrual problems ☐Asthma
☐ Nervousness ☐General Aches ☐Arthritis
☐ Restricted daily activities/recreational activities

Have these led to…

☐Poor decision making ☐Fatigue
☐Inability to exercise ☐Restricted daily activities
☐Lack of patience with family ☐ Decreased productivity

Which one of these problems affects you the most? _________________________________

Have you ever had a massage? ☐Yes ☐No

Have you ever been to a chiropractor? ☐Yes ☐No

Females only: Are you pregnant? Yes or No If so, how many weeks? ___________________

Adult Illness(es): **Check all health/past conditions. CIRCLE all CURRENT conditions.**

☐ Alzheimer's
☐ anemia
☐ arthritis
☐ asthma
☐ blood clots
☐ cancer
☐ cerebral palsy
☐ chicken pox
☐ Crohn's/colitis
☐ CRPS (RSD)
☐ CVA (stroke)
☐ cystic kidney disease
☐ depression
☐ diabetes (insulin dep)
☐ diabetes (non insulin)
☐ eczema
☐ emphysema
☐ eye problems
☐ fibromyalgia
☐ heart disease
☐ hepatitis
☐ HIV
☐ hypertension
☐ influenzal pneumonia
☐ liver disease
☐ lung disease
☐ lupus erythema (discoid)
☐ lupus erythema (systemic)
☐ multiple sclerosis
☐ Osteoprosis/penia
☐ Parkinson's disease
☐ pneumonia
☐ psoriasis
☐ psychiatric problems
☐ Rash(es)
☐ scoliosis
☐ seizures
☐ shingles
☐ STD's (unspecified)
☐ thyroid problems
☐ Vericose veins
☐ vertigo
☐ other:
☐ surgeries in last 6 months___________
☐ Injuries within last 72 hours:

Consent for Treatment:

______I, the undersigned, hereby authorize Advanced Chiropractic to perform a massage. I, also, certify that no guarantee or assurance has been made to the results that may be obtained. I understand and accept that there are some risks associated with massage care and give my consent to proceed with treatment.

______I acknowledge there will be a $25 missed appointment fee if I do not give 24 hour notice when cancelling or rescheduling future massage appointments.

Patient Signature: ____ Date: ____________________________