Welcome To Wagner Family Chiropractic, S.C. -- Massage Intake Form

Client Information

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ❑ M ❑ F Age_____ Birthdate_____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

Insurance

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned Certify that I (or my dependent) have insurance coverage with_____ and assign directly to Wagner Family Chiropractic, SC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Phone Numbers

Home (____)_____Cell (____)_____

Best time and place to reach you_____

Email_____

IN CASE OF EMERGENCY, CONTACT:

Name_____Relationship_____

Home Phone_____

Accident Information

Is condition due to an accident? ❑ Yes ❑ No Date____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑ Other

Attorney Name (if applicable)_____

_____

Client Condition

When did your symptoms begin?_____

What treatment have you already received for your condition?

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Chiropractic Care ❑ None ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain?_____ Is it constant or does it come and go?_____

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

Name and Address of doctor(s) or other healthcare practitioner(s) who have treated you for your condition:

Name_____ Name_____

Address_____ Address_____

Phone (____)_____ Phone (____)_____

Massage History

Have you ever received a professional massage? ❑ Yes ❑ No

Why did you come for our service? ❑ Relaxation ❑ Pain ❑ Therapy ❑ Other_____

What results would you like to acheive?_____

_____

Prioritize the areas of your body that you wish to be massaged. Please note any areas of your body that you **prefer not to be** massaged.

_____

Health History

Please check ☑ conditions or symptoms you currently have or have had in the past:

❑ Anemia	❑ Cancer	❑ Hepatitis	❑ Multiple Sclerosis	❑ Sinus Problems
❑ Anorexia	❑ Chemical Dependency	❑ Hernia	❑ Osteoporosis	❑ Stroke
❑ Appendicitis	❑ Diabetes	❑ Herniated Disc	❑ Pacemaker	❑ Tendonitis
❑ Arthritis	❑ Emphysema	❑ Herpes	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Asthma	❑ Epilepsy	❑ High Blood Pressure	❑ Pinched Nerve	❑ Tuberculosis
❑ Blood Clots	❑ Fibromyalgia	❑ HIV/AIDS	❑ Pneumonia	❑ Tumors, Growths
❑ Breathing Difficulty	❑ Fractures	❑ Jaw Pain/TMJ	❑ Polio	❑ Ulcers
❑ Bursitis	❑ Glaucoma	❑ Lymphedema	❑ Prosthesis	❑ Varicose Veins
❑ Bronchitis	❑ Head Injuries	❑ Migraine Headaches	❑ Rheumatoid Arthritis	❑ Whiplash
❑ Bulimia	❑ Heart Disease	❑ Mononucleosis	❑ Rheumatic Fever	❑ Other_____

Exercise

❑ None
❑ Moderate
❑ Daily
❑ Heavy
Type_____

Work Activity

❑ Sitting
❑ Standing
❑ Light Labor
❑ Heavy Labor

Lifestyle

❑ Smoking Packs/Week_____
❑ Alcohol Drinks/Week_____
❑ Coffee/Caffeine Drinks Cups/Day_____
❑ High Stress Level Reason_____

Are you pregnant? ❑ Yes ❑ No Due Date_____

Please list any medical conditions, surgeries, accidents, and bone, joint, nerve or muscle diseases or injuries not specified above.

_____ _____ _____ _____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that is my responsibility to inform my healthcare provider if I ever have a change in health.

I understand that massage therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis, or treatment by a physician. I understand that individuals providing massage therapy services are not qualified to diagnose, prescribe, or treat any physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from individuals performing massage therapy services is educational in nature and is to be used at my own discretion.

_____ _____
Signature of Patient, Parent, Guardian or personal Representative Date

_____ _____
Please Print Name of Patient, Parent, Guardian or personal Representative Date