



ASULA CHIROPRACTIC & WELLNESS CENTER

NEW PATIENT INTAKE FORM, CHIROPRACTIC & MASSAGE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	Birthdate:	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Race designation: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined <input type="checkbox"/> Unknown/Unavailable <input type="checkbox"/> Other				
Email-address:				
Primary phone:			Type: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work	
Address:		City:	State:	Zip:
Health Insurance:		Policy/subscriber #:		
Chiropractic Patients: Have you ever received chiropractic care?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Massage Patients: Have you ever received massage therapy?				<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you currently suffer from any of the following health complaints?

Check if you have, or have had, any symptoms in the following areas to a significant degree.

<input type="checkbox"/> Headache/Migraines	<input type="checkbox"/> Irritability	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Allergies	<input type="checkbox"/> Weight Trouble
<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Exhaustion
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Depression

Pain/Tension?	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulders	<input type="checkbox"/> Low Back	<input type="checkbox"/> Legs	<input type="checkbox"/> Arms	<input type="checkbox"/> Hands
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Digestive Trouble?	<input type="checkbox"/> Gas	<input type="checkbox"/> Bloating	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Irritable Bowel
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Please indicate on the diagram below any areas where you experience pain or tension.

	Which area bothers you the most?
	How long have you been bothered by the condition?
	Describe how it feels or affects you when it is at its worst.



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MESSAGE CLIENTS only

Please review the list and check any conditions that have affected your health recently or in the past.

<input type="checkbox"/> arthritis	<input type="checkbox"/> auto-immune condition*	<input type="checkbox"/> pregnancy
<input type="checkbox"/> diabetes	<input type="checkbox"/> stroke	<input type="checkbox"/> scoliosis
<input type="checkbox"/> blood clots	<input type="checkbox"/> surgery	<input type="checkbox"/> seizures
<input type="checkbox"/> broken/dislocated bones	<input type="checkbox"/> TMJ disorder	<input type="checkbox"/> whiplash
<input type="checkbox"/> bruise easily	<input type="checkbox"/> nerve pain/loss of sensation	<input type="checkbox"/> heart condition or vascular problems
<input type="checkbox"/> cancer	<input type="checkbox"/> varicose veins	<input type="checkbox"/> tendonitis/bursitis/muscle strain/sprain
<input type="checkbox"/> chronic pain	<input type="checkbox"/> disk problems/spinal injuries	<input type="checkbox"/> skin conditions (rashes, athletes, foot, etc)

*AIDS, fibromyalgia, chronic fatigue, lupus, etc.

If any of the above needs to be detailed or if there is any other health information you would like to share please do so:

Do you have any of the following today?	<input type="checkbox"/> skin rash	<input type="checkbox"/> cold/flu	<input type="checkbox"/> open cuts	<input type="checkbox"/> severe pain	<input type="checkbox"/> injuries/bruises	<input type="checkbox"/> anything contagious
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Do you have any allergies to?	<input type="checkbox"/> medications	<input type="checkbox"/> food(nuts, etc.)	<input type="checkbox"/> environmental allergens	<input type="checkbox"/> reactions to skin care products
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What are your goals/expectations with massage therapy?

PLEASE READ THE FOLLOWING AND SIGN BELOW:

1. I understand that although massage therapy can be very therapeutic, it is not a substitute for medical examination, diagnosis, and treatment.
2. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully and will update the massage therapist of any changes in my health.
3. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
4. A 24-hour cancellation notice is required for any scheduled massage appointments including gift certificates sessions. Missed or no show appointments will result in your being charged a \$20 cancellation fee unless the appointment can be filled. Emergency cancellations are determined at the discretion of Asula Chiropractic and Wellness Center.
5. I have read and understood Asula Chiropractic and Wellness Center Policies and Procedures.

SIGNATURE: _____ **DATE:** _____