Corner on Wellness Chiropractic Center Therapeutic Massage

Patient Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Emergency Contact Name _____ Phone _____

Employer _____ Work Phone _____

Date of Birth _____ Social Security # _____

Is condition due to an injury? ____ No ____ Yes If yes: ____ Auto Accident ____ L& I ____ Other

Date of Injury _____ Do you have a claim currently open? _____ Yes _____ No

Name of Referring Physician _____ Phone _____

L & I INSURANCE INFORMATION *(Required if you have been injured on the job)*

Insurance Company _____ Claim Number _____

Claims Adjuster _____ Phone _____

AUTO INSURANCE INFORMATION *(You may skip this section if you have not been in an auto accident)*

Do you have Personal Injury Protection on your insurance policy? _____ Yes _____ No

Insurance Claim Number _____

Name of Your Insurance Company _____

Address _____

City _____ State _____ Zip _____

Claims adjuster _____ Phone _____

ATTORNEY INFORMATION *(If applicable)*

Name of Attorney _____ Phone _____

Address _____

City _____ State _____ Zip _____

corner on wellness
CHIROPRACTIC CENTER

PLEASE READ CAREFULLY AND SIGN

The information I have provided is complete and accurate to the best of my knowledge and I understand that I am responsible for informing Corner on Wellness Chiropractic Center of any changes in my health condition, or any changes in the information as presented on this form.

I agree to the release of information for medical and/or insurance purposes, and I authorize Corner on Wellness Chiropractic Center to obtain any information from my primary healthcare providers, my attorney and/or my insurance carrier concerning my health, my insurance claim and any legal proceedings as they relate to my treatment.

I clearly understand that massage therapy treatments are my personal financial responsibility; if for any reason payment is denied either by my insurance company or by my attorney, I will make arrangements with Corner on Wellness Chiropractic Center to pay for the massage treatments I have received.

I further understand that I may be charged for appointments cancelled with less than 24 hours notice.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian Signature Date

(If patient is a minor, signature of parent or guardian is required)

WELCOME TO CORNER ON WELLNESS CHIROPRACTIC CENTER

You have made an appointment at Corner on Wellness Chiropractic Center for massage. Your therapist is a professional health care provider who will work with you and your physician to help you achieve your health care goals. Your first appointment with your therapist may last up to 1 hour, due to the time it takes to accomplish the initial assessment of your injuries or condition, and to determine a treatment plan which best suits your needs. Subsequent therapy sessions will be approximately one hour. **Please keep in mind that your Therapist has reserved this time exclusively for you and will not treat any other patients during this time period.** If you find that you will not be able to keep your appointment, please do us the courtesy of calling to inform us so that we may offer the time slot to another patient. Appointments cancelled with less than 24 hours notice will be subject to a $40 fee.

I have read the above statement and I understand that I am responsible for paying to Corner on Wellness Chiropractic Center a $40 fee for any appointment missed without at least 24 hours notice.

Signature: _____ Date: _____

MASSAGE PATIENT INTAKE

Name _____ Date _____

Occupation _____ Have you received massage before? _____

Accidents, Injuries, or Surgeries:

More than 5 years ago: _____

Less than 5 years ago: _____

Are you currently receiving medical or chiropractic care? _____ Yes _____ No

If yes, please explain: _____

_____

Are you currently taking any medication or homeopathics? _____ Yes _____ No

If Yes, please explain: _____

Have you ever experienced any of the following conditions?

__ AIDS
__ Allergies
__ Anemia
__ Arthritis
__ Back Pain
__ Broken Bones
__ Bursitis
__ Cancer
__ Chronic Fatigue Syndrome
__ Circulation Problems
__ Colitis
__ Constipation
__ Diarrhea
__ Diabetes
__ Digestive Problems
__ Disk Problems
__ Diverticulitis
__ Epilepsy Seizures
__ Fibromyalgia
__ Headaches
__ Heart Ailments
__ Hemophilia
__ Herpes Virus
__ High Blood Pressure
__ Insomnia
__ Low Blood Pressure
__ Migraine Headaches
__ Muscle Spasms
__ Numbness
__ Phlebitis
__ Psoriasis
__ Rashes
__ Ringworm
__ Sciatica
__ Skin Allergies
__ Stress
__ Stroke
__ Swollen Feet/Legs
__ Tendonitis
__ Thoracic Outlet Syndrome
__ Tingling
__ TMJ Dysfunction
__ Varicose Veins
__ Whiplash

For Women Only:
__ Excessive Bleeding
__ Lack of Periods
__ Menstrual Cramps
__ PMS

Are you currently experiencing any of the following conditions?

__ Pregnancy __ Flu or Cold __ Infection

__ Inflammation __ Contagious Disease __ Fever

Comments: _____

_____

Substance Use: Alcohol ____ Y ____ N Tobacco ____ Y ____ N

Other _____

Any diet restrictions or regimens? Please describe: _____

_____

Sleep difficulties? Please describe: _____

_____

Do you wear contact lenses? ____ Y ____ N

Regular physical activity: _____What kind? _____

Where do you tend to hold stress in your body? _____

_____

Do you have any especially tender to touch areas? _____

_____

Why have you come for massage? _____

_____

Do you have any allergies to lotions or oils? _____

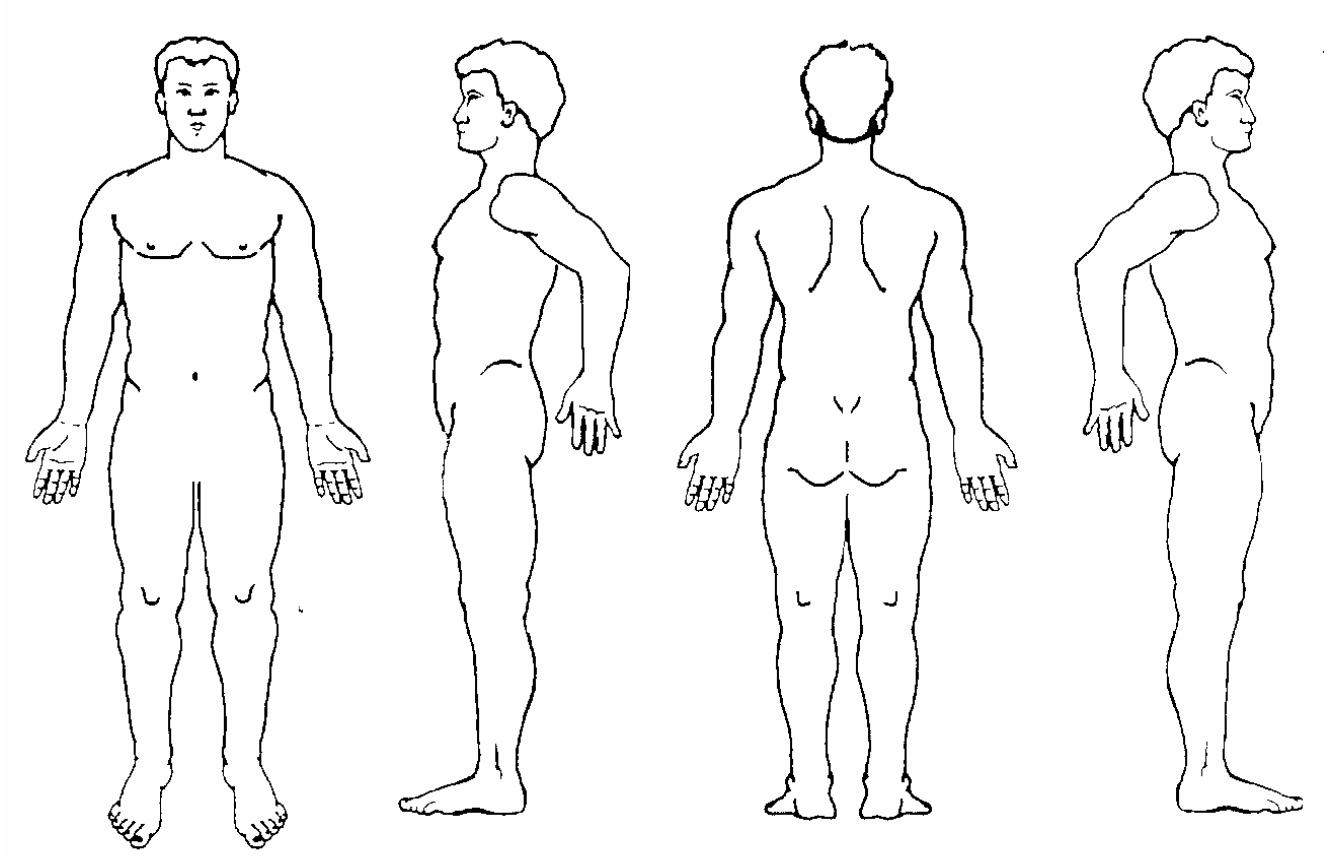
During your massage do you like to carry on a conversation? _____

PERSONAL STATUS REPORT

Name: _____ Date: _____

Identify CURRENT symptomatic areas in your body by drawing the symbols on the figures below.

Key:		
	O	Circle areas of pain
	X	"X" over areas of joint and muscle stiffness
	///	Mark lines along the areas of numbness or tingling
	+++	Mark plus signs on scars, bruises or open wounds



Additional Comments:

_____

_____

_____

BACK PAIN AND DISABILITY QUESTIONNAIRE (revised Oswestry)

Name: _____ Date: _____

This questionnaire has been designed to give the health care provider information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize that you may consider that two of the statements in anyone section relate to you, but please just mark the box which most closely describes your problem today.

SECTION 1 – PAIN INTENSITY

□ The pain comes and goes and is very mild
□ The pain is mild and does not vary much
□The pain comes and goes and is moderate
□ The pain is moderate and does not vary much
□ The pain comes and goes and is very severe
□ The pain is severe and does not very much.

SECTION 2 – PERSONAL CARE

□ I would not have to change my way of washing or dressing in order to avoid pain.
□ I do not normally change my way of washing and dressing even though it causes some pain.
□ Washing and dressing increase the pain but I manage not to change my way of doing it.
□ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
□ Because of the pain I am unable to do some washing and dressing.
□ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 – LIFTING

□ I can lift heavy weights without extra pain.
□ I can lift heavy weights but it causes extra pain.
□ Pain prevents me from lifting heavy weights off the floor.
□ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned.
□ I can only lift very light weights at the most.

SECTION 4 - WALKING

□ I have no pain on walking.
□ I have some pain on walking but it does not increase with distance.
□ I cannot walk more than 1 mile without increasing pain.
□ I cannot walk more than ½ mile without increasing pain.
□ I cannot walk more than ¼ mile without increasing pain.
□ I cannot walk without increasing pain.

SECTION 5 – SITTING

□ I can sit in any chair for as long as I like.
□ I can only sit in my favorite chair as long as I like.
□ Pain prevents me from sitting more than 1 hour.
□ Pain prevents me from sitting more than ½ hour.
□ Pain prevents me from sitting more than 10 minutes.
□ I avoid sitting because it increases my pain straight away.

SECTION 6 – STANDING

□ I can stand as long as I want without pain
□ I have some pain on standing but it does not increase with time.
□ I cannot stand for longer than one hour without increasing pain.
□ I cannot stand for longer than ½ hour without increasing pain.
□ I cannot stand for longer than 10 minutes without increasing pain.
□ I avoid standing because it increases the pain straight away.

SECTION 7 – SLEEPING

□ I get no pain in bed.
□ I get pain in bed but it does not prevent me from sleeping well.
□ Because of pain my normal night's sleep is reduced by less than ¼.
□ Because of pain my normal night's sleep is reduced by less than ½.
□ Because of pain my normal night's sleep is reduced by less than ¾.
□ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

□ My social life is normal and gives me no pain.
□ My social life is normal but increased the degree of pain.
□ Pain has no significant effect on my social life apart from more interests, e.g. dancing , etc.
□ Pain has restricted my social life and I do not go out very often.
□ Pain has restricted my social life to my home.
□ I have hardly any social life because of the pain.

SECTION 9 - TRAVELLING

□ I get no pain whilst traveling.
□ I get some pain whilst traveling but none of my usual forms of travel make any worse.
□ I get extra pain whilst traveling but it does not compel me to seek alternate forms of travel.
□ I get extra pain whilst traveling which compels me to seek alternate forms of travel.
□ Pain restricts all forms of travel.
□ Pain prevents all forms of travel except that done lying down.

SECTION 10 – CHANGING DEGREE OF PAIN

□ My pain is rapidly getting better
□ My pain fluctuates but overall is definitely getting better.
□ My pain seems to be getting better but improvement is slow at present.
□ My pain is neither getting better or worse.
□ My pain is gradually worsening.
□ My pain is rapidly worsening.

NECK PAIN AND DISABILITY QUESTIONNAIRE (Vernon-Mior)

Name: _____ Date: _____

This questionnaire has been designed to give the health care provider information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize that you may consider that two of the statements in anyone section relate to you, but please just mark the box which most closely describes your problem today.

SECTION 1 – PAIN INTENSITY

□ I have no pain at the moment.
□ The pain is very mild at the moment.
□The pain is moderate at the moment.
□ The pain is fairly severe at the moment.
□ The pain is very severe at the moment.
□ The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE

□ I can look after myself normally without causing pain.
□ I can look after myself normally but it causes pain.
□ It is painful to look after myself and I am slow and careful.
□ I need some help but manage most of my personal care.
□ I need help every day in most aspects of self care.
□ I do not get dressed, I wash with difficulty and I stay in bed.

SECTION 3 – LIFTING

□ I lift heavy weights without extra pain.
□ I can lift heavy weights but it gives extra pain.
□ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
□ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
□ I can lift very light weights.
□ I cannot lift or carry anything at all.

SECTION 4 - READING

□ I can read as much as I want to with no pain in my neck.
□ I can read as much I want to with slight pain in my neck.
□ I can read as much as I want to with moderate pain in my neck.
□ I can't read as much as I want because of moderate pain in my neck.
□ I can hardly read at all because of severe pain in my neck.
□ I cannot read at all.

SECTION 5 – HEADACHES

□ I have no headaches at all.
□ I have slight headaches which come infrequently.
□ I have moderate headaches which come infrequently.
□ I have severe headaches which come frequently.
□ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

□ I can concentrate fully when I want to with no difficulty.
□ I can concentrate fully when I want to with slight difficulty.
□ I have a fair degree of difficulty in concentrating when I want to.
□ I have a lot of difficulty in concentrating when I want to.
□ I have a great deal of difficulty concentrating when I want to.
□ I cannot concentrate at all.

SECTION 7 – WORK

□ I can do as much work as I want to.
□ I can only do my usual work, but no more.
□ I can do most of my usual work, but no more.
□ I cannot do my usual work.
□ I can hardly do any work at all.
□ I can't do any work at all.

SECTION 8 – DRIVING

□ I can drive my car without any neck pain.
□ I can drive my car as long as I want with slight pain in my neck.
□ I can drive my car as long as I want with moderate pain in my neck.
□ I can't drive my car as long as I want because of moderate pain in my neck.
□ I can hardly drive at all because of severe pain in my neck.
□ I can't drive my car at all.

SECTION 9 - SLEEPING

□ I have no trouble sleeping.
□ My sleep is slightly disturbed(less than 1 hour sleepless).
□ My sleep is mildly disturbed (1-2 hrs. sleepless).
□ My sleep is moderately disturbed (2-3 hrs. sleepless).
□ My sleep is greatly disturbed (3-5 hrs. sleepless).
□ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – RECREATION

□ I am able to engage in all my recreation activities with no neck pain at all.
□ I am able to engage in all my recreation activities, with some pain in my neck.
□ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
□ I hardly do any recreation activities because of pain in my neck.
□ I can't do recreation activities at all.