corner on wellness CHIROPRACTIC CENTER

Corner on Wellness Chiropractic Center Massage Therapy

NEW PATIENT INFORMATION

Name: ____ Date: _____________________

Address: ____

City: ____ State: __________ Zip: _______________

Phone:____________________________________ Email: _______________________________

Date of Birth: __________________________________

Emergency Contact Information:

Name: ____ Phone: ____________________

Relationship to you: ____

PLEASE READ CAREFULLY AND SIGN BELOW

I understand that payment for treatments I receive at this facility is my personal financial responsibility. I agree to make full payment at the time of treatment. I understand that if I do not make full payment at the time of treatment, a $5.00 billing charge will be added to the charges I owe.

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

____

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

MASSAGE HEALTH HISTORY

Name: ____________________________________ Date: ___________________

Occupation: ____

Do you wear contact lenses? Y N

Are you currently taking any medication? Y N

Are you currently receiving medical or chiropractic care? Y N

Do you have any allergies? Y N
Please list below:
____
____

Have you had massage before? Y N

Are you pregnant, or trying to be? Y N

Was massage prescribed for you? Y N

Do you have any skin conditions? Y N
Please list below:
____
____

How often do you exercise and what kind of exercise?
____
____

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

Do you have any areas that are tender to touch?
____

Illnesses, injuries, surgeries, traumas: please describe and when they occurred.

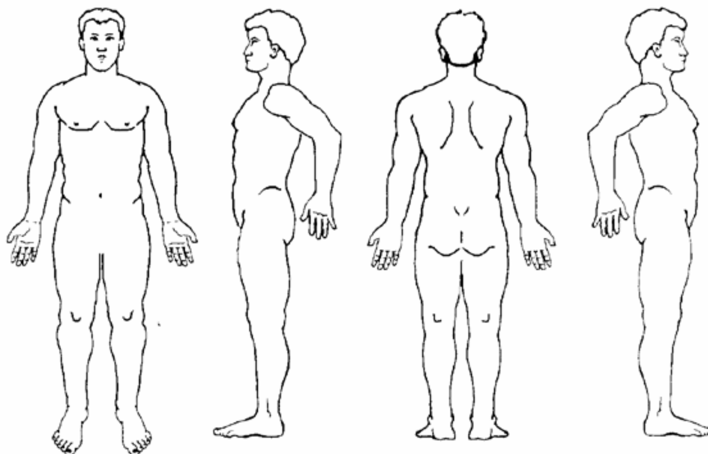
Muscular: _____________________________________
Skeletal: ______________________________________
Circulatory: ___________________________________
Respiratory: ___________________________________

Digestive: ___________________________________
Nervous: ____________________________________
Infectious Disease: ___________________________
Cancer: _____________________________________

Please CIRCLE areas of:

- Stress
- Pain
- Tension
- Special Attention

Please "X" any areas you don't
Want to be touched.
(Genitals are never touched)



The above information is complete and
Accurate to the best of my knowledge ____

Patient Signature Date

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 one 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 last 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 you 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. A patient who arrives more than 15 minutes late for their appointment may be asked to reschedule that appointment. We appreciate your consideration and ask that your fill out the intake forms completely so that your Therapist is able to provide you with the most effective treatment possible.

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 appointments missed without at least 24 hours prior notice.

Signature: ____ Date: _______________________