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First Name__________________ MI____ Last_______________ Birth Date___/___/___ Age_____ Today's Date______________

Address____ City______________________ State_________ Zip______________

Home #(   )_________________________________ Work #(   )__________________________________ Ext.____________

Emergency Contact #(   )_________________ Cell # (   )__________________ E-mail Address_______________________

_________Male _________Female Employer_____________________________ Occupation______________________________

Who may we thank for referring you to our office?______________________ Method of payment for First Visit*: Cash Check CC*

Patient's Health Profile

Please take a moment and carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ________ Yes ________ No How recently?____________

What are your massage or bodywork goals? ____

What kind of pressure do you prefer? ________ Light ________ Medium ________ Firm

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Please check the appropriate box for any of the following symptoms which you now have or have had in the past. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTAIL HEALTH REPORT.

Yes	No	
___	___	Do you frequently suffer from stress?
___	___	Do you have diabetes?
___	___	Do you experience frequent headaches?
___	___	Are you pregnant?
___	___	Do you suffer from arthritis?
___	___	Are you wearing contact lenses?
___	___	Are you wearing dentures?
___	___	Do you have high blood pressure?
___	___	Are you taking high blood pressure medication?
___	___	Do you suffer from epilepsy or seizures?
___	___	Do you suffer from joint swelling?
___	___	Do you have varicose veins?
___	___	Do you have any contagious diseases?
___	___	Do you have osteoporosis?
___	___	Do you have any allergies?

Yes	No	
___	___	Do you bruise easily?
___	___	Any broken bones in the past two years?
___	___	Any injuries in the past two years?
___	___	Do you have tension or soreness in a specific area? Please specify ______________________________
___	___	Do you have cardiac or circulatory problems?
___	___	Do you suffer from back pain?
___	___	Do you have numbness or stabbing pains?
___	___	Are you sensitive to touch or pressure in any area?
___	___	Have you ever had surgery? Explain below.
___	___	Other medical condition or are you taking any medications I should know about?

Comments ____
____

Dynamic Family Chiropractic Terms of Acceptance

Dynamic Family Chiropractic Policies / Procedures:

(Please Initial Next to each Line)

________ 1. All initial services and subsequent fees are payable when services are rendered. (Co-pays, deductibles, etc.)

________ 2. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.

________ 3. If there are any changes in my health profile, I will notify the therapist prior to the start of the session.

________ 4. This is a therapeutic massage and any sexual remarks or advances will terminate the session at the therapists discretion and I will be liable for payment of the scheduled treatment. Rescheduling additional treatments will be determined by management.

________ 5. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

________ 6. A 24-hour notice is required for an appointment cancellation. **A $25 (30 min and 60 min) or $35 (90 min) fees apply for all missed appointments.**

I, ____ have read and fully understand the above statements.
(Print Name)

____ ____________________
(Signature) (Date)