ABOUT THE PATIENT

Delano Chiropractic - 1005 Crossings Dr. Suite 120, Delano, MN 55328

Name ______________________________ Birthdate ________________ Age __________

Address ______________________________ City ____________ State ______ Zip __________

Home Phone ____________ Cell Phone ____________ Work Phone ____________ Gender ❑ M ❑ F

Your Employer ______________________________ Type of Work ______________________

Emergency Contact ____________________ ph # __________ Have you had a massage before? ❑ No ❑ Yes

HEALTH INFORMATION

If you answer "yes" to any of the following questions, please explain.

❑ Yes ❑ No Do you frequently suffer from stress?

❑ Yes ❑ No Do you have diabetes?

❑ Yes ❑ No Do you experience frequent headaches?

❑ Yes ❑ No Are you pregnant?

❑ Yes ❑ No Do you suffer from arthritis?

❑ Yes ❑ No Are you wearing contact lenses?

❑ Yes ❑ No Are you wearing dentures?

❑ Yes ❑ No Do you have high blood pressure?

❑ Yes ❑ No If "yes" to previous question, are you taking medication for this?

❑ Yes ❑ No Do you suffer from epilepsy or seizures?

❑ Yes ❑ No Do you suffer from joint swelling?

❑ Yes ❑ No Do you have varicose veins?

❑ Yes ❑ No Do you have a contagious diseases?

❑ Yes ❑ No Do you have osteoporosis?

❑ Yes ❑ No Do you have any allergies?

❑ Yes ❑ No Do you bruise easily?

❑ Yes ❑ No Have you had any broken bones in the past two years?

❑ Yes ❑ No Have you been in a collision or suffered any injuries in the past two years?

❑ Yes ❑ No Do you have cardiac or circulatory problems?

❑ Yes ❑ No Do you have tension or soreness in a specific area? Please specify: ______________________

❑ Yes ❑ No Do you suffer from neck pain or back pain?

❑ Yes ❑ No Do you have numbness, tingling or sharp pains anywhere?

❑ Yes ❑ No Are you very sensitive to touch or pressure in any area?

❑ Yes ❑ No Have you ever had surgery? ______________________________

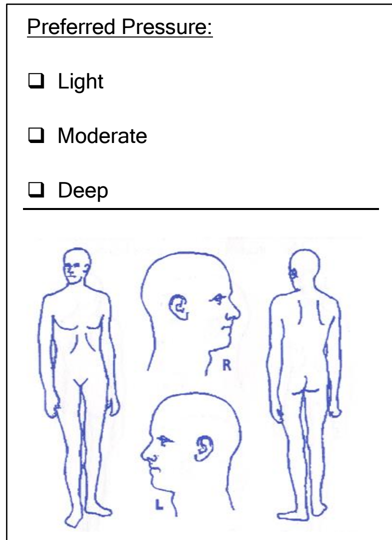
❑ Yes ❑ No Do you have any other medical conditions or are you taking any medications I should know about?

Preferred Pressure:

❑ Light

❑ Moderate

❑ Deep



Comments: ____

- **I understand that any cancellation/no show without giving at least 24 hours notice will be subject to a $35 charge. This rule also applies to any gift certificates purchased by or for the client.**
- I understand that the massage/bodywork I receive is provided for relaxation and relief of muscular tension.
- I will immediately inform the practitioner if I experience any pain or discomfort, so that the pressure and/or strokes may be adjusted.
- I understand that the massage/bodywork should not be construed as a substitute for medical diagnosis or treatment.
- I affirm that I have stated all my known medical conditions.
- I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.
- I understand that any sexually suggestive remarks or advances made by me will result in immediate termination of this session.
- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.
- Person responsible for this account if other than the patient? ______________________

For my balance my preferred method of payment is: ❑ Cash ❑ Check ❑ Credit Card

Patient / Parent Signature Date