



Occupation: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

**Questionnaire:**

Do you have any pain or discomfort?  Yes  No *(check one box)*

If Yes, What areas? \_\_\_\_\_

Any health conditions we should be aware of? \_\_\_\_\_  
\_\_\_\_\_

Have you had Massage therapy before?  Yes  No *(check one box)*

Have you had Chiropractic care before?  Yes  No *(check one box)*

Have you had Physical therapy before?  Yes  No *(check one box)*

Have you been in an automobile accident?  Yes  No *(check one box)*

If Yes, When? \_\_\_\_\_

Where? \_\_\_\_\_

Do you have health insurance?  Yes  No *(check one box)*

If Yes, What is the Company name? \_\_\_\_\_

It is a:  PPO/POS  HMO  Medicare/Medicaid *(check all that apply)*

Do you have a secondary policy?  Yes  No *(check one box)*

If Yes, What is the Company name? \_\_\_\_\_

**Please print these pages and bring them to our office**