

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