PATIENT HISTORY QUESTIONNAIRE

Tracee Peterson, LMP

For office use only:
Pt. ID: _________

Name: ____________________ Home phn ____________________

Address: ____________________ City: ____________________ St: _______ Zip: ____________

Marital Status: M S DP W D Soc. Sec. # ____________________ Birthdate: ________________ Age ________ Sex: M F

Height ________ Weight ________ E-mail Address: ____________________ Cell phn ____________________

Name of Spouse (or parent) ____________________ No. of children & ages: ____________________

Employer: ____________________ Address ____________________

City ____________________ State ____ Zip _______ Wk phn ____________________ Occupation ____________________

Emergency contact: ____________________ Phone: ____________________ Relationship: ____________________

Referred by? ____________________ Type of care desired: _________ Temporary relief ________ Wellness

What is the name of your family physician? ____________________ What city are they located in? ________________

Have you ever had massage therapy before? ______ If yes, when? ____________________

Have you ever had Far Infrared therapy before? ______ If yes, when? ____________________

If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)

1. ____________________ For how long? ____________________
2. ____________________ For how long? ____________________
3. ____________________ For how long? ____________________
4. ____________________ For how long? ____________________

Have you seen anyone else for this complaint? _________ Who & when? ____________________

Did you have a satisfactory result? ____________________

Job Duties: ____________________ What are your hobbies/recreational activities?____________________

Do you exercise regularly? ____ How often? ____________________ What do you do? ____________________

How many glasses/oz. of WATER do you drink per day? ____________________ Do you smoke? ____________________

What vitamins, herbs, or supplements do you take? ____________________

____________________ Are you interested in learning about appropriate nutritional supplementation? _______

Please indicate medications (over the counter) / prescriptions you are currently taking: ❑ Aspirin/Tylenol ❑ Pain Killers ❑ Insulin

❑ Muscle Relaxers ❑ Tranquilizers ❑ Birth Control Pills ❑ Others: ____________________

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: ____________________

Are you pregnant? _____ How far along? ______________ Due Date: ________________ Do you wear contact lenses? _______

Please list any injuries, illnesses or health conditions that you have had that are not listed above: ____________________

____

Please list any conditions that run in your family: ____________________

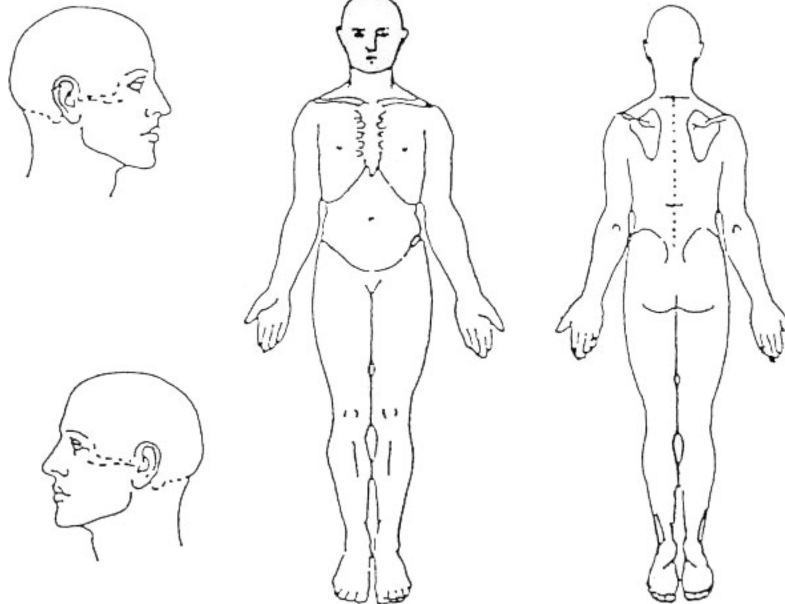
Are you physically tired? ________ Do you have a stressful job or have you recently experienced stressful life events? ____________

Please add any information you feel the therapist should know: ____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, etc.

COMPLETE THESE DIAGRAMS

V V	Ache
= =	Burning
/ /	Numbness
OO	Pins & Needles
+ +	Stabbing, Sharp
X X	Scars, Bruises or Open Wounds



Method of payment for today's charges: ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ ______________________

AUTHORIZATION/RESPONSIBILITY AGREEMENT

I understand that massage is given for the purpose of stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow.

I understand that the massage practitioner does not diagnose illness, disease or any other physical or mental disorder. As such, the massage practitioner does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulation. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a doctor for any physical ailment that I might have.

I have stated all my known medical conditions and take it upon myself to keep the massage practitioner updated on my physical health.

I acknowledge and understand that I am responsible for all charges regarding my massage care. I authorize massage care and accept financial responsibility for myself, or any member of my family who is a minor. I clearly understand that payment is expected at the time of service. I understand the following **cancellation policy:** A 50% fee will be charged for canceling or rescheduling less than 24 hours before your appointment. If you miss your appointment, or cancel within 2 hours of your appointment, you will be charged for one session for time reserved.

By my signature below, I agree to the above, and acknowledge receipt of Burick Chiropractic's **Notice of Privacy Practices.**

Patient's Signature: ____ **Date:** ______________________