NEW PATIENT QUESTIONNAIRE

Patient Name: _____ **DOB:** _____

Gender: M F **Marital Status:** S P M D W **# Children:** _____

Please circle your current health condition: Critical Poor Average Good Great

Medical / Surgical History

Please circle any current or previously diagnosed medical conditions:

Alcoholism	Glaucoma	Osteoporosis
Allergies	Heart Disease	Pregnancy
Anemia	Headaches/Migraines	Psychological
Arthritis	Hepatitis/Liver Disease	Reproductive
Asthma/Emphysema	High Blood Pressure	Respiratory
Broken Bones	High Cholesterol	Seizures
Cancer _____	Hormone Imbalance	Skin Condition _____
Cardiovascular _____	Immune System _____	Stress
Cataracts	Inflammation	Stroke/TIA
Depression	Low Blood Pressure	Swelling
Diabetes	Menstrual	Thyroid Disorder
Dietary Problems	Muscular _____	Urinary
Endocrine/Glands _____	Nervous System _____	Varicose Veins
Fibromyalgia	Numbness/Tingling	Other _____

Do you have any communicable diseases? _____

Please circle any allergies and describe their associated reactions:

Food _____ Latex _____ Medications _____

Animals _____ Plants _____ Other _____

Please list any past surgeries/dates:

_____

_____

Please list any vitamins/supplements/herbs:

_____

_____

Please list all prescription medications you are currently taking and their doses: _____

_____

Office Use Only: Provider signature for LMT/LAc: _____

MASSAGE THERAPY WAIVER & CONSENT FORM

I understand that the massage I receive is provided for the basic purpose of stress reduction and relief of muscular tension. I further understand that the massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for mental or physical ailment that I am aware of.

I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing said in the course of the session should be construed as such. Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

I hereby understand that the practice(s) of Massage Therapy and Acupuncture are a separate and distinct business entity from the practice of Chiropractic provided by Dr. Gretchen Blyss, D.C. of Blyss Chiropractic.

I authorize the following provider(s) to release my medical records in order to obtain payment on my account for massage and/or acupuncture services provided to me.

- Shay Law, LMT Massage License # 16867
- Aaron Annis, LAc, LMT Acupuncture License # AC00817 Massage License # 7948

I authorize payment for such services to be paid directly to the above stated provider(s). I understand that I am financially responsible for any charges not paid for by my insurance carrier(s) or attorney.

Patient Name (Please Print): _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____

CLIENT QUESTIONNAIRE

How are you feeling today? Critical Poor Average Good Great

Have you had a massage before? Yes No **If yes, when?** _____

What areas need special attention? _____

Are there any areas you do NOT want massaged? _____

What is your pain level right now?

0 1 2 3 4 5 6 7 8 9 10

None ***Unbearable***

How much do you symptoms interfere with your daily activities?

0 1 2 3 4 5 6 7 8 9 10

None ***Unable to Perform***

Office Use Only: Providers Signature:

PATIENT REGISTRATION

Effective Jan.1, 2013 all health care clinics are required to have the following information on file. Please complete all sections.

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ **Gender:** Male Female **Weight:** _____ **Height:** _____

Marital Status: Single Married Other **Preferred Language:** English Other: _____

Do You Smoke: Current Former Never **Frequency:** (per day) 1-5 1/2 Pack 1 Pack 2+ Packs

Race: Asian African American White Other: _____

Ethnicity: Decline to Disclose Non-Hispanic Hispanic Mexican Puerto Rican Unknown

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Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____

Email Address: _____

We now offer phone or email reminders, please circle which method you prefer: Cell Home Email

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Employment: Full Time Part Time Student Unemployed Retired Other: _____

Company Name: _____

Job Title: _____

Work Phone: _____ **Ext:** _____

☐ Please check this box if you *do not* want to be contacted at work.

Emergency Contact: _____

(Must be a family member or someone able to make medical decisions on your behalf in the event of a medical emergency.)

Relationship to Patient: _____

Cell Phone: _____ **Home Phone:** _____