CONFIDENTIAL PATIENT INFORMATION

Name_____Home Phone_____

Cell phone_____ Email address_____

Address_____ City_____State_____Zip_____

Age_____ Birth date_____ Marital Status ___M ___S ___D___W Number Of Children_____

Your Occupation_____Employer_____

Employer Address_____ Work Phone _____

Name Of Spouse/Parent_____ Their Employer_____

Referred By_____

Emergency contact not living with you_____

Their relationship to you_____ Their phone_____

Symptoms we are seeing you for_____

_____

Are your symptoms worse in the ____ morning ____during the day ____evenings ____ night ____same all day

Rate the severity of your worst symptom (circle) No pain 1 2 3 4 5 6 7 8 9 10 unbearable pain

What makes your symptoms better_____worse_____

Other doctors seen for this condition_____

List any surgeries you have had and date_____

_____

List any major illnesses you have had and date_____

_____

List any medications you are taking_____

If female are you pregnant _____ no _____ yes If yes, due date_____

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS BILLING INSURANCE

Do you have health insurance _____no _____yes Social security number_____

Primary insurance name_____ Secondary Ins_____

Who is insured_____ Relationship_____

Person responsible for payment_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, and that Lembke Chiropractic Clinic will assist me in making collections from the insurance company, I authorize that payment from the insurance companies for services at this office be made directly to Lembke Chiropractic Clinic. However I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment in full. I also authorize the release of my medical records to my present or future insurance company.

Patient's Signature_____ Date_____

Information Taken By _____Date_____

Massage Therapy Medical History Form

Name:_____ Date:_____ Date of Birth:_____

Occupation:_____

Have you ever had massage therapy before? Y N Date of last massage:_____

For women: Are you pregnant? Y N If so, how many months:_____

Do you have any difficulty lying on your front, back, or side? Y N
If yes, please explain_____

Do you have any skin allergies to oils, lotions, ointments etc… Y N
If yes, please explain_____

Do you sit for long periods during the day? Y N
If yes, please describe_____

Do you perform any repetitive movements in your day? Y N
If yes, please describe_____

Do you experience stress in your work, family, or other aspect of your life? Y N
If yes, please explain_____

What is your stress level: High____ Medium___ Low___

Is there a particular area of the body where you are experiencing tension, stiffness, or other discomfort? Y N
If yes, please identify_____

Are you currently under medical supervision? Y N
If yes, please explain_____

Please list any medications you are currently taking, including aspirin, ibuprofen, etc….
_____
_____

Do you have, or have you ever had any infectious diseases? Y N
If yes, please explain_____

Have you had any significant injuries? Y N
If yes, please explain_____

Please check any condition listed below that applies to you:

___High/Low Blood Pressure	___Fatigue/Sleep Disorders	___Allergies
___Heart Conditions	___Dislocations	___Arthritis
___Cancer	___Recent Infections	___Lupus
___Diabetes	___Tendonitis	___Varicose Veins
___Epilepsy	___Bursitis	___Blood Clots
___Stroke	___Sprains/Strains	___Lung Conditions
___Fibromyalgia	___Headaches	___Spinal Conditions
___Nervous System Disorders	___Abdominal Conditions	___Broken Bones

Are there any other conditions that your massage therapist should know about?

_____

_____

PLEASE READ AND SIGN:

I understand that massage practitioners do not diagnose illness, disease, or any other physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals. I acknowledge that massage is not a substitute for medical examination or diagnosis, and it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update my massage practitioner of any changes to my health status.
I acknowledge that I will have to pay for any missed appointments if they are not cancelled within 24 hours (barring emergencies).

SIGNATURE:_____ **DATE:**_____

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Lembke Chiropractic Clinic

Address: 11015 NE 4th Plain Rd Ste B, Vancouver, WA 98662

Phone: (360) 892-0451

Website: https://www.vancouverwashingtonchiropractor.com/

Hours

Monday	8:00 AM - 6:00 PM
Tuesday	8:00 AM - 12:00 PM
Wednesday	8:00 AM - 6:00 PM
Thursday	8:00 AM - 12:00 PM
Friday	8:00 AM - 6:00 PM