Emerald Coast Chiropractic

Name ______________________________ Home Phone ____________________

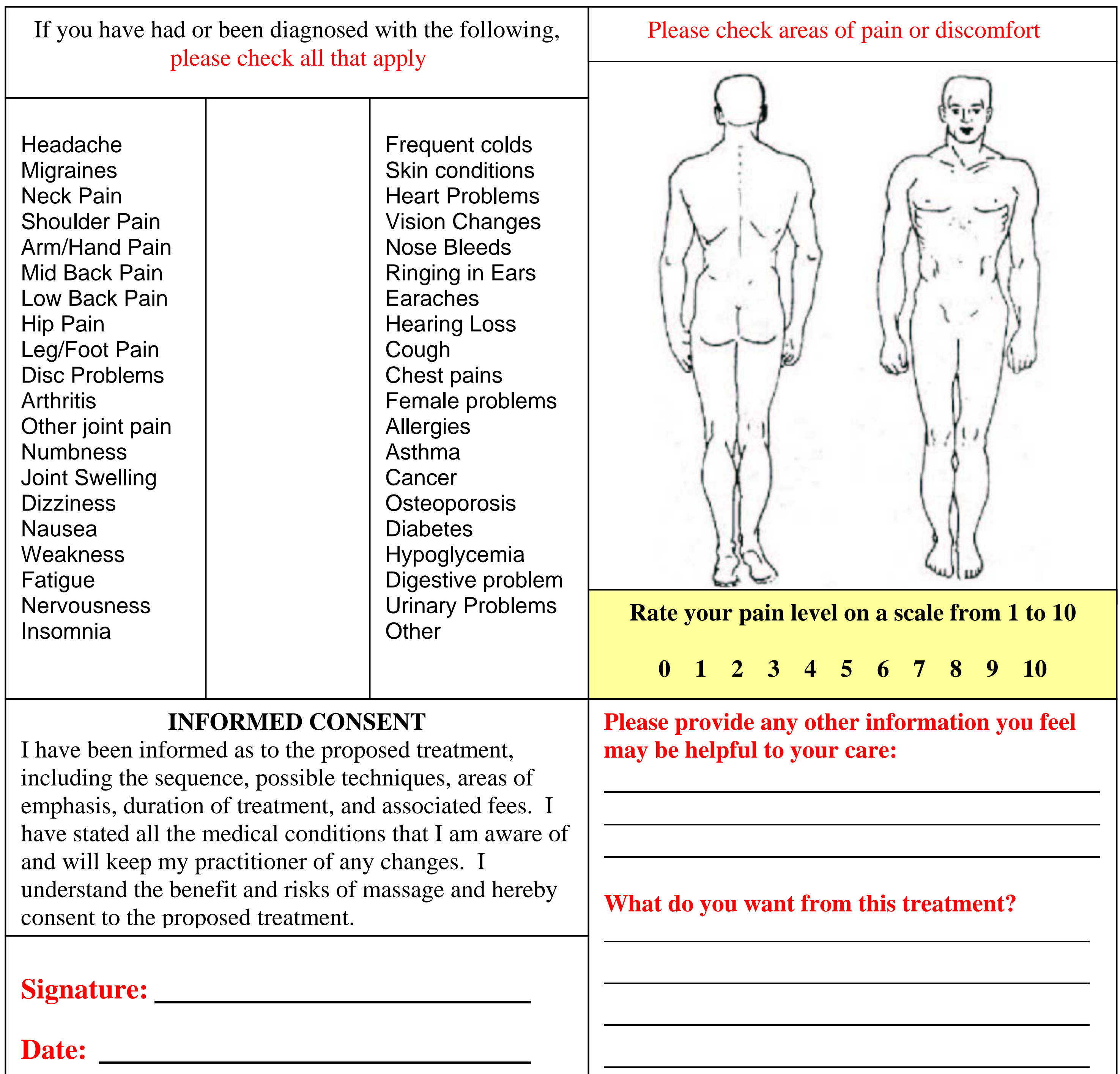
Address ______________________________ Cell Phone ____________________

City ______________________________ State __________ Zip ____________

Date of Birth ______________________________ SSN# ____________________

E-mail ______________________________

Marital Status (circle one) Single Married Other # of Children ____________



If you have had or been diagnosed with the following, please check all that apply

Headache		Frequent colds
Migraines		Skin conditions
Neck Pain		Heart Problems
Shoulder Pain		Vision Changes
Arm/Hand Pain		Nose Bleeds
Mid Back Pain		Ringing in Ears
Low Back Pain		Earaches
Hip Pain		Hearing Loss
Leg/Foot Pain		Cough
Disc Problems		Chest pains
Arthritis		Female problems
Other joint pain		Allergies
Numbness		Asthma
Joint Swelling		Cancer
Dizziness		Osteoporosis
Nausea		Diabetes
Weakness		Hypoglycemia
Fatigue		Digestive problem
Nervousness		Urinary Problems
Insomnia		Other

Please check areas of pain or discomfort

Rate your pain level on a scale from 1 to 10

0 1 2 3 4 5 6 7 8 9 10

INFORMED CONSENT

I have been informed as to the proposed treatment, including the sequence, possible techniques, areas of emphasis, duration of treatment, and associated fees. I have stated all the medical conditions that I am aware of and will keep my practitioner of any changes. I understand the benefit and risks of massage and hereby consent to the proposed treatment.

Signature: ______________________________

Date: ______________________________

Please provide any other information you feel may be helpful to your care:

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What do you want from this treatment?

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SUBMIT