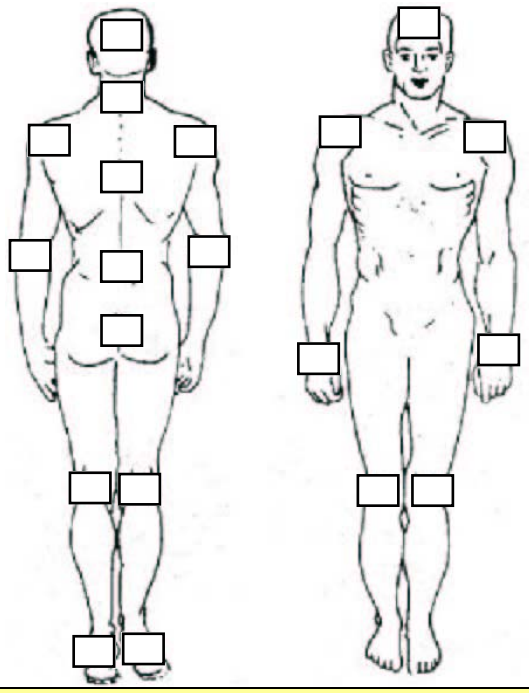
Emerald Coast Chiropractic

Name _____ Home Phone _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____
Date of Birth _____ SSN# _____
E-mail _____
Marital Status (check one): ☐ Single ☐ Married ☐ Other # of Children _____

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

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

_____
_____
_____

What do you want from this treatment?

_____
_____
_____
_____

SUBMIT