Riverview Family Chiropractic

Patient Information:

Name:________________________________ Date: ____________________________________

Address:______________________________ Home Phone:_____________________________

City:_________________________________ Work Phone:_____________________________

Referred By:___________________________ Cell Phone:______________________________

Sex: Male☐ Female☐ Marital Status: M☐S☐D☐W☐

Date of Birth__________________________ Social Security #: _________________________

Drivers Lic #: ___________ Exp Date: _____

Employer: ____________________________ Occupation: _____________________________

Employer Address:____

Emergency Contact: _________________________________ Phone #: _________________________

History:

Reason for Visit: ____

Have you had a massage prior to this visit? YES ☐ NO ☐

Personal Health Habits:

Smoke YES ☐ NO ☐ How much? _______________How Long? _______________

Drink Caffeine? YES ☐ NO ☐ How much? _______________How Long? _______________

Alcohol? YES ☐ NO ☐ How much? _______________How Long? _______________

For Females Only:

Are you pregnant? YES ☐ NO ☐ Date of last menstrual cycle _____________________

Before Treatment:

If you have any recent or chronic medical conditions, please check here:

☐ Dislocations	☐ Back Injuries	☐ Neck Injuries	☐ Fractures
☐ Pulled Muscles	☐ Stiff Neck	☐ Broken Bones	☐ Headaches
☐ Muscle Cramps	☐ Back Pain	☐ Diabetes	☐ Arthritis
☐ Recent Surgery	☐ Skin Problems	☐ Sores	☐ Numbness
☐ Bruise Easy	☐ Fainting Spells	☐ Varicose Veins	☐ Dizziness
☐ Open Lesions	☐ Nerve Problems	☐ High Blood Pressure	☐ Hepatitis
☐ Cancer	☐ Inflammations	☐ Car Accident	☐ Numbness

Other: ____

Medications:

Medicine Name/Dosage:	Reason:	How Often:
____________________	______________________	______________________
____________________	______________________	______________________
____________________	______________________	______________________
____________________	______________________	______________________

Taken Antibiotics in the last year? YES ☐ NO ☐

Allergic to any chemicals, scents or ointments? YES ☐ NO ☐

If so, please list: ____

I have read the above and have answered honestly to the above questions and will discuss it with the therapist. I understand that this bodywork does not constitute medical treatment, but rather is a form of health maintenance. I take responsibility for alerting my therapist to any physical conditions that would affect this work.

Please allow 24 hours notice of appointment cancellations. We reserve the right to charge for any missed appointments not given sufficient notice of cancellation. Payment is due at the time services are rendered.

Signed: ______________________________ Date:____________________________