KIK CHIROPRACTIC
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Massage Therapy Patient Information Form

PATIENT INFORMATION

Today's date ________________________

Name ______________________________________ Male _________ Female __________

Birth Date ___________________

Mailing Address ____

City ____________________________ State ________________ Zip _______________

Home Telephone ______________________ Business Telephone ____________________

Mobile or Pager Number __________________________

Do you have insurance that covers massage therapy? Yes _____ No _____

If yes, please list the Insurance Company name ____________________________________

Occupation _________________________ Marital Status Single ____ Married ____

Spouse' Name ___________________________ Spouse's Telephone ____________________

REASON FOR VISIT

The reason for this visit is (please circle):

WORK SPORTS AUTO ACCIDENT

TRAUMA OR INJURY CHRONIC PROBLEM

Please explain the reason for your visit here: ____

____

When did this problem begin? _________________ Is this problem getting worse? __________________

Have you had this or similar conditions in the past? ____

PATIENT HEALTH HISTORY

Are you taking any medications? No ___________ Yes ____________

If yes, please list all of them: _____________________ _______________________

_____________________ _______________________

_____________________ _______________________

Are you presently under medical care for any conditions? No _________ Yes __________

If yes, please list all of them: ____

_____________________ ______________________________

____

What is your health history, please list all previous illnesses, diseases, conditions, accidents, and/ or surgery (please include all dates)

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Please list anything that you are or may be allergic to

____

____

Please indicate any concerns or possible contraindications that you might have to massage therapy

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Please answer the following questions (circle one): Are you pregnant? Yes No

Do you get skin rashes? Yes No

How did you hear about us? ____

MISSED APPOINTMENT AND CANCELLATION POLICY

I acknowledge if I am unable to keep a scheduled massage appointment, I will notify the Kik Chiropractic office 24 hours in advance. I understand that if Kik Chiropractic is unable to find a replacement for my appointment slot and I do not give a timely cancelation notice, I will be personally responsible to pay for the appointment.

Signature ____ Date __________________