Name: ____Birthdate:________________

Address:________________________________ City:_____________State: _____ZIP:________

Phone:__________________________ E-mail: ____

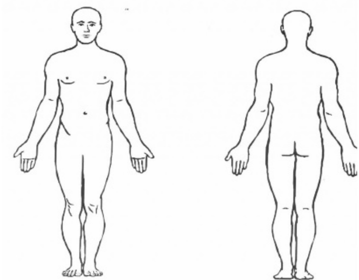
What is the number one thing that bothers you the most today? _________________________

____

How and when did this begin? ____

____

Pain Level: 0 1 2 3 4 5 6 7 8 9 10 on and off constant



Where does it bother you most? ___________________________

Type of pain: sharp stabbing burning achy dull stiff & sore

Radiating: left / right skull shoulder arm leg hand hip knee foot ribs other

Are you? getting better staying the same getting worse

What makes it better? ice heat rest movement stretching other: _______________

Worse? sitting standing walking lying down sleep overuse other:_______________

Have you seen anyone else for this condition? ______________________________________

Any other treatments?

____

Any history with Chiropractic?

____

Were you involved in an accident? auto work accident fall

other:________________

____

List of prescription medications:

____

List of past Surgeries:

____

____

Do you have any other physical complaints?

____

____

How did you hear about us?

____

Any Insurance? Company: ______please provide your card______

Massage Release:

I understand that should I receive massage therapy at Wood Chiropractic the service is for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my sessions, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I agree that I have listed all my known medical conditions and answered all questions honestly. I agree to keep my practitioners updated as to any changes in my medical profile and

understand that there shall be no liability on the practitioner's part should I fail to do so.

Patient Signature: ________________________________ Date: ___________________