Lemire Chiropractic
Spine & Sport Inc

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PATIENT INFORMATION

NAME: _____ HOME # _____

ADDRESS: _____ CELL # _____

CITY: _____ STATE _____ ZIP _____ EMAIL: _____

SEX: ☐ M ☐ F DATE OF BIRTH __/__/___ AGE: _____ SOCIAL # _____

EMPLOYER/ OCCUPATION: _____ WORK # _____

EMERGENCY CONTACT/ RELATIONSHIP _____ CONTACT # _____

PLEASE COMPLETE THIS SECTION FOR INSURANCE

INSURANCE CARRIER: _____ ID # _____

GENERAL & MEDICAL INFORMATION

Have you ever had a professional Massage? ☐ Y ☐ N If yes, how often? _____

Are you pregnant? If yes, how far along are you? _____

Are you allergic or sensitive to any oils (essential oils, nut oils, scents, etc.)? If yes, Please list:

_____

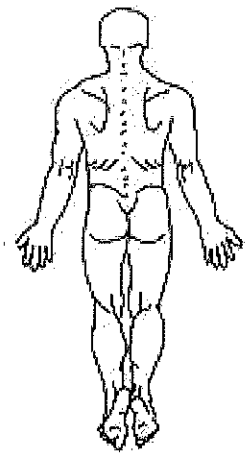
List of current medications and reason: _____

_____

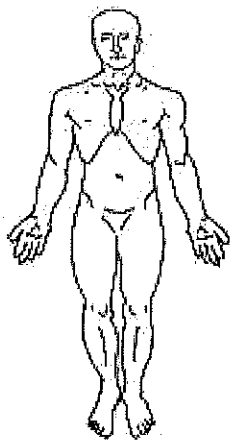
List of surgeries (type and date) _____

PAIN DRAWING AND DESCRIPTION

It is important that your registered massage therapist knows where you have stiffness, numbness, tingling and any type of pain. Please mark the areas on the figures below that correspond to any pain or altered sensation you're experiencing.



P P P = Pins and Needles
NNN = Numbness
XXX = Burning
A A A = Aching
TTT = Tingling
SSS = Stiffness
/// = Stabbing



We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:

- Twenty-four hour advance notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment.

No-shows

- Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". They will be charged for their "missed" appointment.

Late Arrivals

- If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session. Out of respect and consideration to your therapist and other customers, please plan accordingly and be on time.

Information and Suggestions

- Prior to your massage, please remove jewelry that may get in the way of are being treated.
- Pull long hair back with a clip or band.
- Feel free to ask your therapist any questions before, during, or after the session. Your therapist is a highly trained professional and will be happy to make you feel informed and comfortable.

Massage Client Waiver Form

I, _____, (client) understand that massage therapy provided by: Universal Chiropractic Massage Therapist, is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I give my consent to receive treatment.

I have been informed about the fee for my service, and the office cancelation policy. I understand and agree to abide by it.

_____ _____

Print Patient's Name Witness

_____ _____

Signature of Patient Date Signed

_____

Date Signed

Lemire Chiropractic Spine & Sport Inc
Health Survey

Name: Age: Today's Date

Please mark all conditions you have now, or have had in the past:

General
- ☐ Allergies
- ☐ Dizziness
- ☐ Fevers
- ☐ Fainting
- ☐ Fatigue
- ☐ Depression
- ☐ Weight loss
- ☐ Loss of sleep
- ☐ Night Sweats
- ☐ Bruise Easily
- ☐ Hernia
- ☐ Surgeries

_____

_____

Muscle/Joint
- ☐ Arthritis
- ☐ Bursitis
- ☐ Swollen Joints
- ☐ Whiplash
- ☐ Foot/Ankle trouble
- ☐ Hip trouble
- ☐ Shoulder trouble
- ☐ Elbow trouble
- ☐ Wrist trouble
- ☐ Jaw trouble

Cardiovascular
- ☐ Heart Attack
- ☐ Stroke
- ☐ Open Heart Surgery
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Poor Circulation
- ☐ Fast Heart Rate

Genitourinary
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ Prostate Problems

Women
- ☐ Never Pregnant
- ☐ Now Pregnant # of Months ____
- ☐ Previously Pregnant # of Births ___

Systemic
- ☐ Aids
- ☐ Alcoholism
- ☐ Anorexia/ Bulimia
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Gout
- ☐ Herpes
- ☐ Measles
- ☐ Mumps
- ☐ Multiple Sclerosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other

_____

Family History – Please Mark Conditions present in your Family
- ☐ Auto Immune Disorder
  Who? /_____
- ☐ Arthritis
  Who? _____
- ☐ Back Trouble
  Who? _____
- ☐ Cancer
  Who? _____
  What Type: _____
- ☐ Diabetes
  Who? _____
- ☐ Heart Disease
  Who? _____
- ☐ Kidney Disease
  Who? _____
- ☐ Seizure Disorder
  Who? _____

Patient's Signature _____ **Date** _____