MOUW FAMILY CHIROPRACTIC

CONFIDENTIAL HEALTH SCREENING QUESTIONNAIR FOR MASSAGE

Date_____ How did you learn about us?_____

Last Name_____First Name_____ M.I._____

Street Address_____ City_____ Zip_____

Phone: Cell_____ Home_____ Work_____

Occupation/Activities:_____

Date of Birth _____ Age_____ Sex: ☐ Female ☐ Male

** I have been given and read the HIPAA information for Mouw Family Chiropractic **

Signature _____

Have you ever experienced any of the following? Please use 'C' for current, 'P' for past and 'S' for sometimes

__HIV/AIDS	__Cancer	__Disc Problems	__High Blood Pressure	__Rashes	__Tendonitis
__Allergies	__Chronic Fatigue	__Eczema	__Low Blood Pressure	__Ringworm	__Tumors
__Anemia	__Circulatory Problems	__Epilepsy/Seizures	__Insomnia	__Sciatica	__Varicose Veins
__Athletes Foot	__Colitis	__Fibromyalgia	__Excess Stress	__Stiff Joints	__Whiplash
__Arthritis	__Constipation	__Headaches	__Migraines	__Skin Allergies	__Other_____
__Back Pain	__Diarrhea	__Heart Attack/Ailments	__Muscle Spasms	__Sprains/Strains	_____.
__Bone Fractures	__Diabetes	__Hemophilia	__Numbness/Tingling	__Stroke	
__Bursitis	__Digestive Problems	__Herpes	__Psoriasis	__Swollen Feet/Legs	

For Women Only:

__Pregnant	__Excessive Bleeding	__Menstrual Cramps
__Trying to be pregnant	__Amenorrhea	__PMS

Accidents, Injuries, or Surgeries:

Less than 5 years ago_____

More than 5 years ago_____

Are you currently receiving medical or chiropractic care? ☐ Yes ☐ No

If yes please explain_____

Are you taking any medications? ☐ Yes ☐ No

If yes please explain_____

The reason you have come for massage today_____

Have you ever received a massage before? ☐ Yes ☐ No

Please read and sign the following:

I acknowledge that the above information is complete and accurate to the best of my knowledge and that I will notify Mouw Family Chiropractic and/or treating LMT of any changes in my physical condition prior to my massage.

I am also aware that payment is due on the date of service.

A missed appointment or cancellation with less than 24 hours notice will be charged $35.00

Signature_____ Date_____

Please indicate areas of tension/ aches/pain

(N) where you would NOT like to be touched

Genitals will never be touched

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗