Circle Chiropractic
Dr. Ben Duke
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New Massage Patient Form

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Date: _____

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Birthdate: _____ **Social Security Number:** _____ **Height:** _____ **Weight:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone – Mobile: _____ **Home:** _____ **Work:** _____

Email: _____

Employer: _____ **Occupation:** _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Spouse's Name: _____ **Children:** _____

How did you hear about us? ◯ Referral ◯ Walk-in ◯ Phone Book ◯ Website ◯ Other: _____

Referred by: ◯ Family ◯ Friend ◯ Physician ◯ Other Name: _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

CURRENT CONDITION

Complaints: (list your complaints in order of severity)

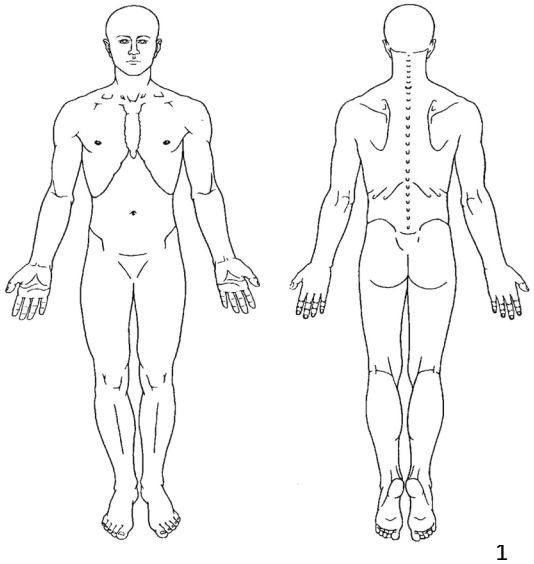
_____

_____

_____

_____

Indicate on the diagram below the location of your symptoms:



Rate your pain on a scale of 0—10, with 0 being no pain at all and 10 being the worst pain imaginable:

◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

0 1 2 3 4 5 6 7 8 9 10

How long have you been experiencing symptoms? _____

Do you know what caused the problem(s)? _____

Quality: Describe your pain. ◯ Aching ◯ Burning ◯ Cramping ◯ Deep ◯ Dull ◯ Numb ◯ Radiating ◯ Sharp ◯ Shooting ◯ Sore ◯ Stabbing ◯ Stiff ◯ Swelling ◯ Tight ◯ Tingling ◯ Throbbing ◯ Other: _____

Does the pain travel to any other areas? Please explain: _____

Aggravating Factors: What makes the problem worse? ◯ Nothing ◯ Most movements ◯ Bending ◯ Carrying things ◯ Coughing ◯ Driving ◯ Eating ◯ Exercise ◯ Going up/down stairs ◯ Going from lying to sitting ◯ Going from lying to standing ◯ Going from sitting to standing ◯ Heat ◯ Housework ◯ Ice ◯ Jogging ◯ Lifting ◯ Lying down ◯ Massage ◯ Pulling ◯ Pushing ◯ Running ◯ Sitting ◯ Sleeping ◯ Sneezing ◯ Squatting ◯ Standing ◯ Prolonged standing ◯ Stress ◯ Stretching ◯ Taking a deep breath ◯ Turning ◯ Twisting ◯ Walking ◯ Working

What treatments have you tried for your condition? ◯ None ◯ Acupuncture ◯ Anti-inflammatories ◯ Bracing ◯ Chiropractic Care ◯ Elevation ◯ Exercise ◯ Heat ◯ Ice ◯ Massage ◯ Movement ◯ Pain medication ◯ Physical therapy ◯ Rest ◯ Stretching ◯ Surgery ◯ Walking ◯ Wraps ◯ Other: _____

Did any of the above provide relief? ◯ No ◯ Yes (Please explain): _____

Relieving Factors: What makes the problem better? _____

What daily activities are affected due to the problem(s)? ◯ None ◯ Bathing ◯ Caring for children ◯ Climbing stairs ◯ Cleaning ◯ Cooking ◯ Doing laundry ◯ Dressing ◯ Driving ◯ Eating ◯ Exercising ◯ Grooming ◯ Going from lying to sitting ◯ Going from sitting to standing ◯ Housework ◯ Lying down ◯ Lifting ◯ Oral care ◯ Sex ◯ Shopping ◯ Sitting ◯ Standing ◯ Sleeping ◯ Social/recreational activities ◯ Stretching ◯ Toileting ◯ Using technology ◯ Walking ◯ Working ◯ Yard work

Females only: Are you pregnant? ◯ Yes ◯ No

DAILY HABITS

Tobacco use: ◯ Never Smoked ◯ Current daily smoker ◯ Current occasional smoker ◯ Former smoker

Caffeinated beverages: ◯ None ◯ 1 to 5 ◯ 6 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ Over 20 **Per:** ◯ Day ◯ Week ◯ Month

Pain relievers: _____

Daily water intake: _____

CONDITIONS

Please indicate any conditions that you currently have or have had in the past:

Have | Had	Have | Had	Have | Had	Have | Had
◯ | ◯ Arm/hand pain	◯ | ◯ Arthritis	◯ | ◯ Cancer	◯ | ◯ Chest pain/pressure
◯ | ◯ Dizziness/lightheadedness	◯ | ◯ Ease of bruising	◯ | ◯ Epilepsy	◯ | ◯ Edema (swelling)
◯ | ◯ Facial pain	◯ | ◯ Fainting	◯ | ◯ Fibromyalgia	◯ | ◯ Foot/leg pain
◯ | ◯ Fractures	◯ | ◯ Head injury	◯ | ◯ Headache	◯ | ◯ Herniated Disc
◯ | ◯ Hip pain	◯ | ◯ Joint pain	◯ | ◯ Knee pain	◯ | ◯ Leg cramping
◯ | ◯ Low back pain	◯ | ◯ Mid back pain	◯ | ◯ Migraine Headaches	◯ | ◯ Muscle pain
◯ | ◯ Neck pain	◯ | ◯ Neuralgia	◯ | ◯ Numbness	◯ | ◯ Osteoporosis
◯ | ◯ Pacemaker	◯ | ◯ Parkinson's Disease	◯ | ◯ Pinched Nerve	◯ | ◯ Rheumatoid Arthritis
◯ | ◯ Seizures	◯ | ◯ Shoulder pain	◯ | ◯ Sinus pressure/pain	◯ | ◯ Stiffness
◯ | ◯ Stroke	◯ | ◯ Swelling of joints	◯ | ◯ Tingling	◯ | ◯ Tremors
◯ | ◯ Upper back pain	◯ | ◯ Vertigo	◯ | ◯ Weakness	
◯ | ◯ Other: _____			

Are there any other illnesses, operations, injuries, treatments, or other information that we should be aware of that may affect your treatment today?

_____

_____

_____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concerns.

_____

Print Name of Patient

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the boxes below, I authorize being contacted for practice reminders by:

Mail □

Email □ Email address: _____

Phone □ Phone Number(s): _____

Voicemail □

By checking the boxes below, I authorize being contacted for birthday greetings or promotions about the practice by:

Mail □

Email □ Email address: _____

Phone □ Phone Number(s): _____

Voicemail □

By checking the line below, I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____

Patient Name (please print) Date

_____

Signature of Patient, Parent, Guardian, or Patient's legal representative

_____

Name of Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____