ON THE GO CHIRO

3250 N. Campbell Ave., Ste.132, Tucson, AZ 85719 **520.881.0650**

Patient Registration and Massage Questionnaire

Name: _____ Age: _____ Date of Birth: _____ Date: _____
LAST FIRST MIDDLE

Address: _____ ☐ Male ☐ Female

City, State, Zip: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children _____

Home Phone (_____)_____ Work Phone (_____)_____

Cell Phone (_____)_____ Email _____

Employer_____ Occupation_____

How did you find out about us? _____

In case of emergency, notify _____ Relationship: _____ Phone (_____)_____

Have you had a professional massage before? ☐ Yes ☐ No How recently?_____

What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm ☐ Deep Tissue

What type of massage are you seeking today? ☐ Relaxation ☐ Deep Tissue ☐ Therapeutic ☐ Prenatal ☐ Sports

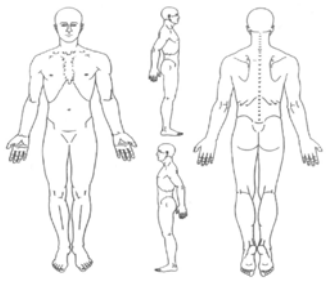
Are you sensitive to fragrances or perfumes? ☐ Yes ☐ No If yes, what? _____

Are you pregnant? ☐ Yes ☐ No If yes, how far along? _____

What is your pain **right now**? 0 1 2 3 4 5 6 7 8 9 10
No pain worst possible pain

Please mark on the diagram to the right the following symbols as they relate to your symptoms:

SS = spasms ST = stiffness
DP = dull pain SP = sharp pain
SH = shooting pain TI = tingling
NU = numbness A = ache
BN = burning TH = throbbing



Please list all medications and dosage: **Frequency** **For What Illness?**

_____

_____

List any allergies to medications, food or other: _____

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Patient's Name: _____ Date: _____

Please list all serious illness and serious accidents: **Month and Year** **City, State**

_____

_____

_____

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

_____

_____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes

Any other condition(s) not listed above that the doctor should be made aware of:

_____

HIPAA Compliance

ON THE GO CHIRO is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witness:_____ Date: _____

Staff Initials: _____

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Informed Consent

I hereby consent to the performance of massage therapy by the therapist named below at On The Go Chiro. Massage in general provides benefits of stress reduction, relief from muscle tension, spasm, or pain and it increases circulation and energy flow. I understand that massage therapists do not diagnose illness or disease, perform any spinal manipulations, nor do they prescribe any medical treatments.

A 60-minute massage session includes 50 minutes of hands-on time and 10 minutes for consultation and dressing. A 90-minute massage session includes 80 minutes of hands-on time and 10 minutes for consultation and dressing.

The therapist must be aware of all heath conditions due to certain contraindications or cautions for massage. I have disclosed all such conditions. I will also update any changes to my health in future sessions.

If at any time during the massage the client or therapist is uncomfortable for any reason, they shall immediately say so. Sexual advances of any kind will not be tolerated.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the massage and the related treatment. I have discussed it with the therapist and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that in was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient Printed Name_____ **Date**_____

Patient Signature_____ **LMT.** _____

The patient had the following questions and was supplied the following answers:

_____

_____

It is my clinical opinion this patient is oriented to time and space: Yes No

It is my clinical opinion this patient was able to understand the language involved: Yes No