GREATER ROCHESTER *family & sports* CHIROPRACTIC

30 Allens Creek Rd.
Rochester, NY 14618
TEL (585) 442-3220
FAX (585) 442-1017
www.greater**rochester**chiropractic.com

MASSAGE THERAPY **PATIENT INFORMATION**

NAME: ______________________________ DATE: ______________

CURRENT ADDRESS: ______________________________

CITY: ______________________ STATE: _________ ZIP: ______________

PHONE :(H) ________________ (W) ________________

DATE OF BIRTH: ______________ AGE ______ STATUS: S M W D SPOUSE: ______________

OF CHILDREN: ______________ OCCUPATION: _ _ _ _ _ _ _ _ _ _ _ _ _ _

NAME & ADDRESS OF EMPLOYER: ______________________________

SPOUSE'S EMPLOYER: ______________________________

PRIMARY CARE PHYSICIAN: ______________ TEL.: _ _ _ _ _ _ _ _ _ _ _ _ _ _

ADDRESS: ______________________________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

HEALTH INFORMATION

Main complaint: ______________________________

Other complaint(s):

____

How long have you had this condition? ______________ ______________

Have you had similar conditions in the past? ______________

Does this condition affect your work? ☐ Yes ☐ No

Does this condition affect your family or social life? ☐ Yes ☐ No

What aggravates this condition? ______________

Are you taking any medication? (please specify) ______________

What helps your symptoms? ______________

Have you had any surgery, falls or accidents? ☐ Yes ☐ No

When? __________ Please describe ______________

Date of last physical examination ______________

How often do you wear seatbelts when you drive? ______________

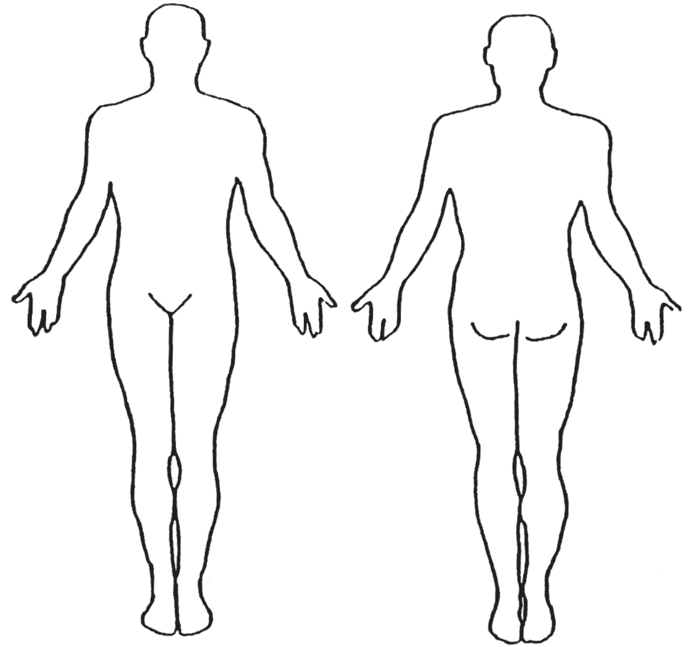
How often do you floss your teeth? ______________

Do you wear contacts? ☐ Yes ☐ No

Do you exercise 3X/week? ☐ Yes ☐ No

CURRENT MEDICAL COMPLAINTS

Please indicate the location and type of discomfort you are feeling:



SHARP AND STABBING ††††
DULL AND ACHEY vvvv
PINS AND NEEDLES 0000
NUMBNESS //////

Do you experience pain every day? ❑ Yes ❑ No

____

Does your pain wake you up during the night? ❑ Yes ❑ No

____

Does your pain worsen with sexual activity? ❑ Yes ❑ No

____

Do weather changes affect your pain? ❑ Yes ❑ No

____

Currently, the pain is increased when I:

Sit	❑ Yes	❑ No	Climb	❑ Yes	❑ No
Stand	❑ Yes	❑ No	Crouch	❑ Yes	❑ No
Rise from a chair	❑ Yes	❑ No	Kneel	❑ Yes	❑ No
Walk	❑ Yes	❑ No	Push	❑ Yes	❑ No
Reach above shoulder level	❑ Yes	❑ No	Lift	❑ Yes	❑ No
Repeated lifting	❑ Yes	❑ No	Bend	❑ Yes	❑ No
Reach below shoulder level	❑ Yes	❑ No			
Reach at shoulder level	❑ Yes	❑ No			

Check if you suffer from any of the following:

____ Coronary Heart Disease	____ Respiratory Conditions	____ Epilepsy
____ Cardiac Disease	____ Shortness of Breath	____ Allergies
____ Heart Murmur	____ Tuberculosis	____ Angina
____ Irregular Heartbeat	____ High Blood Pressure	____ Arthritis
____ Nervous Disorder	____ High Cholesterol	____ Rheumatism
____ Rheumatic Fever	____ Varicose Veins	____ Stroke
____ Kidney Disease	____ Peripheral Vascular Disease	____ Diabetes
____ Bone/Joint Condition	____ Muscle/Tendon Condition	____ Gout
____ Emphysema	____ Poor Eyesight	____ Hernia
____ Poor Hearing	____ Chronic Bronchitis	____ Asthma

Do you suffer from:

Headaches	❑ Yes	❑ No	Neck Pain	❑ Yes	❑ No	Arm/Shoulder Pain	❑ Yes	❑ No
Back Pain	❑ Yes	❑ No	Hip/Leg Pain	❑ Yes	❑ No	Abdominal Pain	❑ Yes	❑ No
Chest Pain	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No	Heart Trouble	❑ Yes	❑ No
Palpitations	❑ Yes	❑ No	Circulatory	❑ Yes	❑ No	Hi/Lo Blood Pressure	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Prostate Prob.	❑ Yes	❑ No	Kidney Problems	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No	Constipation	❑ Yes	❑ No	Anemia	❑ Yes	❑ No
Depression	❑ Yes	❑ No	Loose Stool	❑ Yes	❑ No	Female Problems	❑ Yes	❑ No
Swollen joints	❑ Yes	❑ No	Insomnia	❑ Yes	❑ No	Bladder Problems	❑ Yes	❑ No
Numbness	❑ Yes	❑ No	Nervousness	❑ Yes	❑ No	Digestive Disorder	❑ Yes	❑ No
Gen. Fatigue	❑ Yes	❑ No	Hot Flashes	❑ Yes	❑ No	Lung/Bronchial Problems	❑ Yes	❑ No
Poor Memory	❑ Yes	❑ No	A.M. fatigue	❑ Yes	❑ No			