BELDE CHIROPRACTIC & body shop

Please take just a few moments to fill out this questionnaire.
This will help us serve you better!

Today's Date_____

Name_____ Date of Birth_____

Address_____ City/State/Zip_____

Phone: Home_____ Work_____ Cell_____

Email address_____

Type of Employment_____ Any lifting involved? Yes No

Do you have health insurance? Yes No Name of carrier_____

How did you hear about our office? _____

Please answer the following:

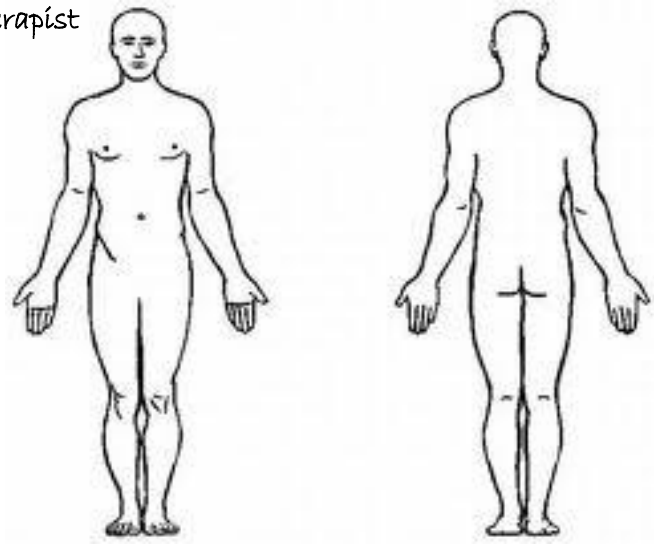
1. Have you ever had massage or chiropractic care before? Yes No Did it help? Yes No
2. Are you currently under a physician's care for an acute or chronic illness? Yes No
   If yes, please explain._____
3. Are you currently taking any prescribed medication or dietary supplements? Yes No
   If yes, please explain._____
4. Do you presently have any of the symptoms below? (Please circle any that apply)

NECK PAIN	SHOULDER PAIN	MID BACK PAIN
LOWER BACK PAIN	RADIATING LEG PAIN	LEG NUMBNESS
NUMBNESS	TINGLING	HEADACHES
BLURRED VISION	RINGINING OF EARS	NAUSEA
KNEE PAIN	ANKLE OR FOOT PAIN	HIP PAIN

   OTHER SYMPTOMS_____

5. Have you been involved in a motor vehicle accident within 1 year? Yes No
6. Have you been involved or are you treating for a work injury? Yes No
7. Have you been involved in any slip and fall or personal injury claim within 1 year? Yes no
8. Please list any recent injuries or surgery within the past 5 years._____
   _____
9. What are your goals for this session?_____
10. Please prioritize areas of tension, stress and/or pain you wish to be addressed._____
    _____

Circle any specific areas you would like the massage therapist to concentrate on during your session.



I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. If I experience any pain or discomfort I will inform my massage therapist immediately.

_____

Signature/Date