



Gerken Family Chiropractic

88 E Bonita Road, Suite E, Chula Vista, CA 91910 Phone: (619) 422-3088 Fax: (619) 422-3988

PERSONAL INFORMATION

Name: First:	Last:	Middle Initial:
Date:	Home Phone: ()	Cell : ()
Address:		City:
State:	Zip:	Date of Birth:
EMAIL :		
Referred by:		

QUESTIONS

Have you had massage/bodywork done before?
What is your primary symptom or reason for coming today?
What brought on your symptoms?
What aggravates or makes your symptoms more severe?
What improves or makes your symptoms less severe?
Do your symptoms interfere with sleep, work or daily routine?
Are you sensitive to touch or do you bruise easily?
Describe the exercise activities that you do and it's frequency?
What are your intentions, expectations or goals for your massage today?
Please list any additional information you would like me to be aware of regarding your health?

CONDITIONS

Mark all of the following that apply to you:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Contagious Disease
<input type="checkbox"/> Pregnant/Nursing	<input type="checkbox"/> Numbing or Stabbing Pain
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Taking Medications
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Over The Counter Supplements
<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Allergies
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other? _____

In the last two years, has anything happened that could effect your massage?

<input type="checkbox"/> Surgery	<input type="checkbox"/> Accidents / Trauma
----------------------------------	---------------------------------------------

Medications

List any medications you are currently taking:

Medication	Reason	Medication	Reason
1 _____		3 _____	
2 _____		4 _____	

Occasionally we send out newsletters, announcements and special occasion cards. If you do not want to receive these please indicate here: No Thanks

I understand and agree to the following:

- That the purpose of the massage/bodywork is stress reduction, relief from muscular tension, spasms, pain, to improve circulation and to enhance one's sense of well being. If I experience any pain, discomfort, or if I prefer a change in the method of being used, I will immediately inform the therapist so the pressure or methods can be adjusted to my comfort level
- That the therapist does not diagnose illness or disease, perform spinal manipulation or prescribe medical examination, diagnosis or treatment
- That the massage/bodywork should NOT be performed under certain medical circumstances and I agree to keep the therapist updated as to any changes in my health status. I release the massage therapist from any liability should I fail to do so
- That all time involved will be documented. All forms and charting will be kept confidential. I release Gerken Family Chiropractic from any liability.
- Cancellation must be within 24 hours or I will be charged full price

Patient Name

Patient Signature (Parent/Guardian if under 18 years)

Date