

MESSAGE INTAKE

Welcome to Hawthorne Chiropractic!
Please take a moment to provide us with the following information.
If you have any questions, please let one of us know.

TODAY'S DATE _____

ABOUT YOU

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Age _____ Date of Birth: _____

SSN: _____

Occupation _____ Daily # of hrs worked: _____

Work Activities: _____

Employer _____

How did you hear about us? _____

If a person referred you, we will thank them with a free 30-minute massage or chiropractic treatment.

INSURANCE INFORMATION

(Some insurance companies have massage coverage. We would be happy to check for you.)

Name of insured? _____

Birth Date (of insured): _____

SSN#: _____

Relationship to patient: _____

Insurance Co: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional Insurance? _____

Subscriber's Name: _____

Birth Date: _____ SSN#: _____

Relationship to patient: _____

Insurance Co: _____

Address: _____

(We must have a photocopy of both sides of your insurance card(s))

PHONE NUMBERS

Home: _____

Work: _____

Is it OK to call you at Work Yes No

Mobile: _____

E-mail: _____

Emergency Contact

Name: _____

Relationship: _____

Home #: _____

Work #: _____

Primary Care Physician: _____

GENERAL INFORMATION

Have you had a professional massage before?

Have you had any recent surgeries or injuries?

Where do you feel you hold stress?

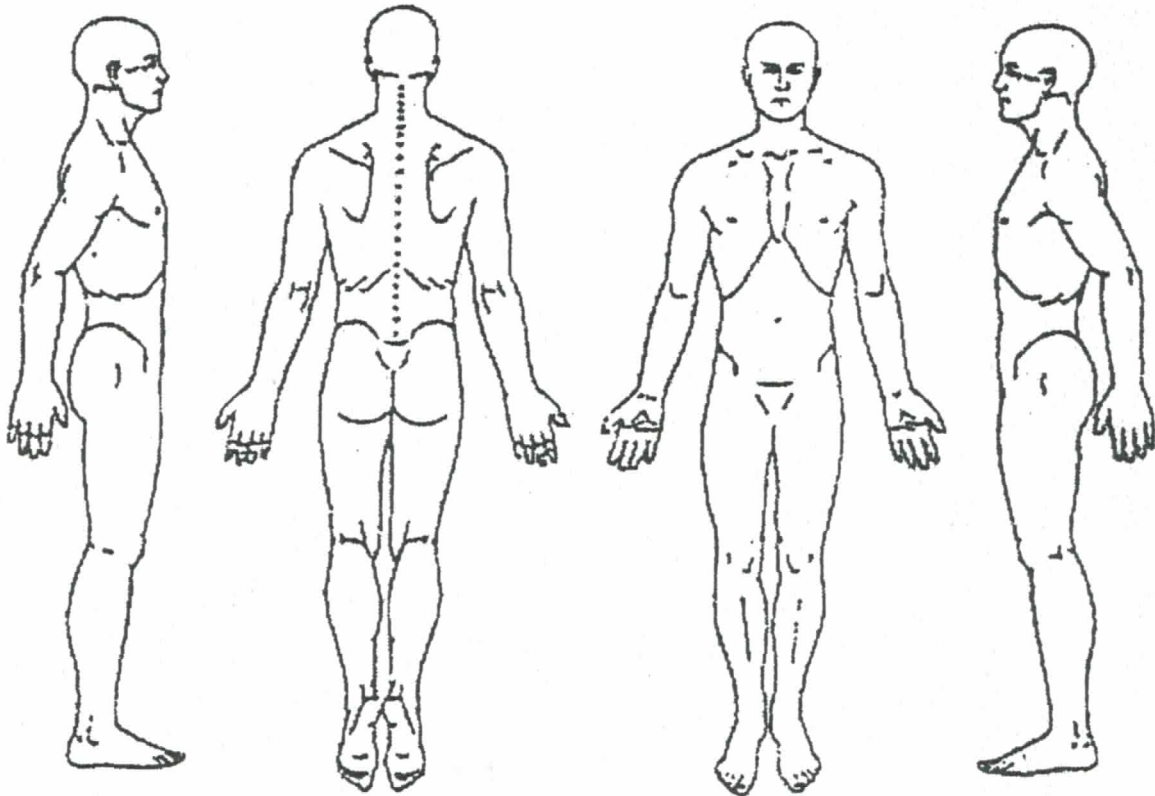
Are you currently seeing other health care providers (acupuncturist, chiropractor, naturopath, md, etc)?

Check all that apply to your current health...

- | | |
|--|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> teeth grinding |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> chronic pain |
| <input type="checkbox"/> allergies (lotions/balms) | <input type="checkbox"/> bruises |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> high/low bp |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> sprains/strains |
| <input type="checkbox"/> pain meds | <input type="checkbox"/> infectious conditions |
| | (athlete's foot, etc.) |

Patient: _____ Date: _____ DOB: _____

Please indicate where you are feeling pain...



Describe your pain. (sharp, burning, stiff, sore, dull, achy, shooting, stabbing, weak, numb, tingly)

How frequently do you feel pain? (constantly, often, occasionally, intermittently)
