CONFIDENTIAL

HEALTH INFORMATION

Anderson Bauman Chiropractic

Dr. Michael Anderson
Dr. Ryan Bauman
Dr. Susan Reinke
733 N Pine Street
Burlington, Wi 53105
www.notjustbackpain.com

Please allow our staff to photocopy your driver's license. All information you supply is confidential. We comply with all federal privacy standards. Please Print Clearly

____
Today's Date:

Whom may we thank for referring you? ______________________ **Age** ____________ **Birth Date: (MM/DD/YYY)** ______________

Gender
Male ◯ Female◯

Patient Last Name ______________________ **Patient First Name** ______________________ **Patient Middle Name (Or initial)** ______________________

Address ____ **Nick Name** ______________________

City ______________________ **State/Province** ______________ **Zip/Postal Code** ______________

Marital Status ◯ Married
◯ Single ◯ Separated
◯ Divorced ◯Widowed

Home Phone ______________________ **Cell Phone** ______________________

Email Address ____ **Primary Physician** ______________________

Emergency Contact Name ______________________ **Emergency Contact Number** ______________________

Patient Occupation ______________________ **Patient Employer** ______________________

Massage Information:

Have you had a professional massage before? ◯ **Yes** ◯ **No**

What type of Massage are you seeking? ◯ Relaxation ◯ Therapeutic/ Deep tissue
◯ Other___________________________________

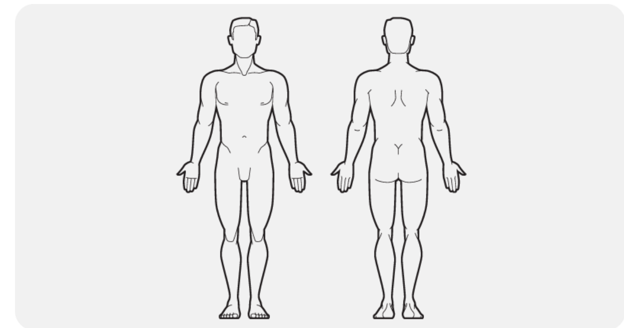
What Pressure do you prefer?
◯ Light ◯ Medium ◯ Deep

Do you have any allergies or sensitivities? ____

Are there any areas (feet, face, abdomen, etc.) you do not want massaged?
____

What are you goals for this treatment session? ______________________________________

Please mark any areas of discomfort



Medical Information:

Are you taking any medications? ◯**Yes** ◯ **No**

If yes, please list name and use: ____

Are you currently pregnant? ◯Yes ◯ No If yes, How far along? _______________________

Do you suffer from recurring pain? ◯**Yes** ◯**No**

If yes, Please explain ____

What makes it better? __________________ **What makes it worse?** ____________________

Have you had any orthopedic injuries? ◯**Yes** ◯ **No**

If yes, please list: ____________________________

Please indicate any of the following that apply to you:
◯ Cancer ◯Headaches/Migraines ◯Arthritis
◯Fibromyalgia ◯ Numbness ◯ Sprains/Strains
◯ Other ______________________________

Explain any conditions you have marked above:
____
____

By Signing Below, you agree to the following: I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time

____ ________________________________
Patient Signature **Date**