



CONFIDENTIAL HEALTH SCREENING QUESTIONNAIRE FOR MASSAGE

Date _____ How did you learn about us? _____

Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ Zip _____

Phone: Cell _____ Home _____ Work _____

Occupation/Activities: _____

Date of Birth _____ Age _____ Sex: Female Male

** I have been given and read the HIPAA information for Mouw Family Chiropractic **

Signature _____

Have you ever experienced any of the following? Please use 'C' for current, 'P' for past and 'S' for sometimes

- | | | | | | |
|---|---|--|--|--|---|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rashes | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Eczema | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ringworm | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Athletes Foot | <input type="checkbox"/> Colitis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Excess Stress | <input type="checkbox"/> Stiff Joints | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Skin Allergies | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heart Attack/Ailments | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Sprains/Strains | _____ |
| <input type="checkbox"/> Bone Fractures | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Swollen Feet/Legs | |

For Women Only:

- | | | |
|--|---|---|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Trying to be pregnant | <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> PMS |

Accidents, Injuries, or Surgeries:

Less than 5 years ago _____

More than 5 years ago _____

Are you currently receiving medical or chiropractic care? Yes No

If yes please explain _____

Are you taking any medications? Yes No

If yes please explain _____

The reason you have come for massage today _____

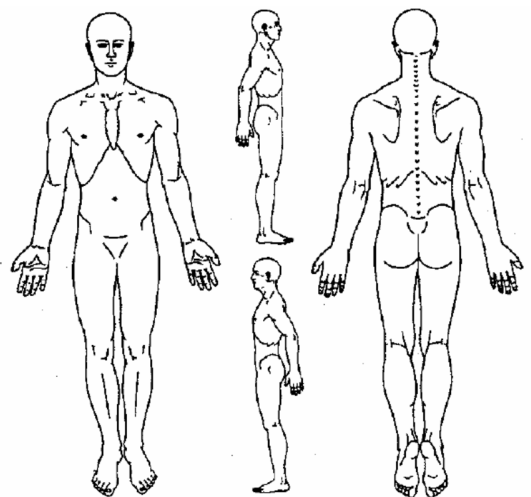
Have you ever received a massage before? Yes No

Please indicate areas of tension/ aches/pain

(N) where you would NOT like to be touched

Genitals will never be touched

| | | | | |
|----------|----------------|---------|---------|----------|
| Numbness | Pins & Needles | Burning | Aching | Stabbing |
| ----- | o o o o | ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |
| ----- | o o o o | ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |
| ----- | o o o o | ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |



Please read and sign the following:

I acknowledge that the above information is complete and accurate to the best of my knowledge and that I will notify Mouw Family Chiropractic and/or treating LMT of any changes in my physical condition prior to my massage.

I am also aware that payment is due on the date of service.

A missed appointment or cancellation with less than 24 hours notice will be charged \$35.00

Signature _____ Date _____