Back on Track Chiropractic

3335 South Airport Road W., Ste. 6A, Traverse City, MI 49684
Phone (231) 922-0421 www.backontrackmi.com

PERSONAL DATA

Name_____ Age _____ Date of Birth _____
Parents' names (if you are under 18) _____
Home Address_____ City _____ State_____ Zip _____
Home Phone (_____) _____ Business Phone (_____) _____
Cell Phone (_____) _____ E-Mail Address_____
Occupation_____ Employer _____
Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner's Name:_____
Who may we thank for referring you to our office? _____

HEALTH INFO

Purpose of this appointment: _____
Have you had a professional before? ❑ Yes ❑ No
How was your experience? _____
Are you currently begin treated by another doctor? ❑ Yes ❑ No
If Yes, Who are you seeing? _____
What are your goals for treatment?_____
Height:_____ Weight: _____
Do you exercise or participate in any sports? ❑ Yes ❑ No If yes, describe _____
Do you perform any repetitive movements in your work, sports, or hobby? ❑ Yes ❑ No
If Yes, describe _____
Do you sit for long hours at a workstation, computer, or driving? ❑ Yes ❑ No
If Yes, describe _____
Do you experience stress in your work, family, or other aspect of your life? ❑ Yes ❑ No
If Yes, describe _____
Have you recently had an injury, surgery, or areas of inflammation? ❑ Yes ❑ No
If Yes, describe _____
Do you have sensitive skin? ❑ Yes ❑ No
Do you have any allergies to oils lotions or ointments? ❑ Yes ❑ No
If Yes, describe _____
Are you taking any medication? ❑ Yes ❑ No
If Yes, What are you taking? _____
Additional patient comments:
_____
_____

FOR WOMEN ONLY

Are you pregnant? ❑Y ❑N Possible/Unknown If Yes, Due Date? _____

PHYSICAL INFO

Physical, emotional and chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

Many common symptoms and conditions are caused by the interference and stress on the nerve system. Please place a (X) on conditions that you are currently suffering from and a (O) on any conditions you have had in the past.

__Arthritis
__Back Curvature
__Mental / Emotional Disorders
__Diabetes
__Swollen or Painful Joints
__Convulsions / Epilepsy
__Skin Problems
__Bruise Easily
__Cancer
__Allergies
__Frequent Colds
__Upper Back Pain / Stiffness
__Excessive Gas
__Constipation / Diarrhea
__Prostate Problems
__Impotence
__Kidney Problems
__Frequent Urination
__Menstrual Problems / PMS
__Menopausal problems

__Headache
__Migraine Headache
__Neck Pain R/L
__Shoulder Pain R/L
__Numbness or Tingling in arms, or hands R/L
__Carpal Tunnel Syndrome R/L
__Dizziness
__Ringing in Ears
__Hearing Loss
__Loss of Balance
__Digestive Problems
__Depression
__Attention Disorder
__Anxiety Disorder
__Eating Disorder
__Trouble Concentrating
__Loss of memory
__Ear Infection
__Learning Disability

__Asthma
__Chest Pain
__Difficult Breathing
__Heart Problems
__Heart Attack
__Stroke
__Bruit
__High / Low Blood Pressure
__Varicose Veins
__Liver Trouble
__Gall Bladder Trouble
__Mid Back Pain / Stiffness
__Pain with cough, or strain
__Hip Pain
__Low Back Pain / Stiffness
__Sciatica
__Numbness or Tingling in legs or feet R/L
__Muscle Tightness
__Trouble sleeping

I hereby certify that the information provided is true and accurate.

Patient Signature: _____ Date: _____

MISSED APPOINTMENT AND CANCELLATION POLICY

If you are unable to keep your scheduled appointment, please give as much notice as possible. When you book a massage you are receiving the therapist's time, and that time will be held for you until you inform us otherwise. You must give at least 2 hours notice to ensure you are not charged for the appointment.

If you are unable to give sufficient notice of cancellation you will be charged 50% of the cost of the massage. If your visit was to be billed to insurance, you will be charged half of the equivalent cash rate.

By signing below you confirm that you have received and understood this policy.

.

Patient Signature: _____ Date: _____

General Liability Release Form

By signing below, you agree to the following:

1) I give my permission to receive massage therapy.
2) I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.
3) I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.
4) I have clearance from my physician to receive massage therapy.
5) I understand the risks associated with massage therapy include, but are not limited to:
    - Superficial bruising
    - Short-term muscle soreness
    - Exacerbation of undiscovered injury

    I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.
6) I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.
7) I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.
8) I understand that I or the massage therapist may terminate the session at any time.
9) I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

_____ _____

Signature Date