Sunbury Chiropractic
www.sunburychiropractic.com
123 State Route 3
Sunbury, OH 43074
Phone: 740.965.4301
Fax: 740.965.5182

Your local path to wellness™

Johnstown Chiropractic
www.johnstownchiropractic.com
620 West Coshocton Street
Johnstown, OH 43031
Phone: 740.967.2225
Fax: 740.967.8907

PERSONAL HEALTH INFORMATION

Name: ____ Date: ______________________
Address: ______________________________ City, State, Zip: _____________________________

Birth Date: ____/____/____ Marital Status: M S D W Occupation: ____________________
Referred By: ________________________________

Cell Phone: _____________ Cell Phone Carrier: ______________ Home Phone: ______________
Email: ____________________________ Preference for Reminder Appointments: *Email* *Text*

Family Physician: ______________________________ Date of Last Physical: _______________
Emergency Contact: __________________________________ Phone: _______________________

SCC has permission to discuss care/finances with (Name) _______________________________
(Relationship) _______________________ (Phone Number) _______________________________

MASSAGE HISTORY / TREATMENT INFORMATION

Have you ever received a professional massage? Yes _____ No _____
What results do you want from your massage sessions? ______________________________
____
If you're experiencing pain, rate your pain on a scale 1–10 with 10 being the worst ______
At rest – scale 1–10 ______ Activity – scale 1–10 ______

List current medications, including: aspirin, ibuprofen, etc. __________________________
____

Are you currently seeing a psychotherapist or are you attending regular support group meetings? Yes or No Please explain if yes: ______________________________________
____
List exercise activities (include frequency): _____________________________________
____
Rate your degree of body flexibility: ( ) Excellent ( ) Good ( ) Fair ( ) Poor

PREVIOUS MEDICAL HISTORY: (include year and treatment received)

Surgeries: ____
____

Accident: (automobile – childhood – industrial – etc.) _______________________________

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HEALTH HISTORY

Musculo-Skeletal

_____ bone or joint disease ____________________
_____ tendonitis ____________________
_____ bursitis ____________________
_____ broken/fractured bones ____________________
_____ arthritis ____________________
_____ sprains/strains ____________________
_____ low back, hip, leg pain ____________________
_____ neck, shoulder, arm pain ____________________
_____ spasms/cramps ____________________
_____ jaw pain/TMJ ____________________
_____ painful feet ____________________
_____ fibromyalgia ____________________
_____ sciatica ____________________
_____ other ____________________
_____ herpes/shingles ______________

Circulatory

_____ heart condition ____________________
_____ varicose veins ____________________
_____ blood clots ____________________
_____ high blood pressure ____________________
_____ low blood pressure ____________________
_____ lymphedema ____________________
_____ swelling in feet or ankles ____________________
_____ other ____________________
_____ last menstrual cycle ____________

Infectious Disease

_____ disease name(s) ____________________
_____ endometriosis ________________

Lungs

_____ difficulty breathing ____________________
_____ sinus problems ____________________
_____ allergies ____________________
_____ smoke/frequency ____________________
_____ asthma ____________________
_____ bronchitis ____________________
_____ other ____________________

Skin

_____ allergies ____________________
_____ rashes ____________________
_____ athlete's foot ____________________
_____ bruises easily ____________________
_____ other ____________________

Digestive

_____ constipation ____________________
_____ gas/bloating ____________________
_____ diverticulitis ____________________
_____ IBS ____________________
_____ other ____________________

Nervous System

_____ numbness/tingling ___________
_____ chronic pain ____________________
_____ fatigue ____________________
_____ sleep disorders ____________________
_____ epilepsy ____________________
_____ other ____________________

Females Only

_____ pregnant/stage ________________

_____ menstrual cramps ______________
_____ PMS ____________________

_____ lumps/pain in breasts ___________
_____ bloating ____________________
_____ menopause ____________________
_____ other ____________________

Males Only

_____ painful/slow urination
_____ other ____________________

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Other

_____ cancer/tumors _______________
_____ eating disorders _______________
_____ diabetes _____________________
_____ depression ___________________
_____ anxiety/panic attacks __________
_____ alcohol/frequency ___________
_____ headaches/frequency __________

Eyes

_____ glasses/contacts _____________________

Massage Pressure Preference:

Light _________ Firm ________ Deep ________

FOR OFFICE USE ONLY:
Massage therapy recommended for health and therapeutic value.
Yes _____ No _____
Dr. Signature ____ Date:_____________________
OPTIONS:
One month _____ One/Three months _____ Three/Six months_____ One year_____ As needed _____

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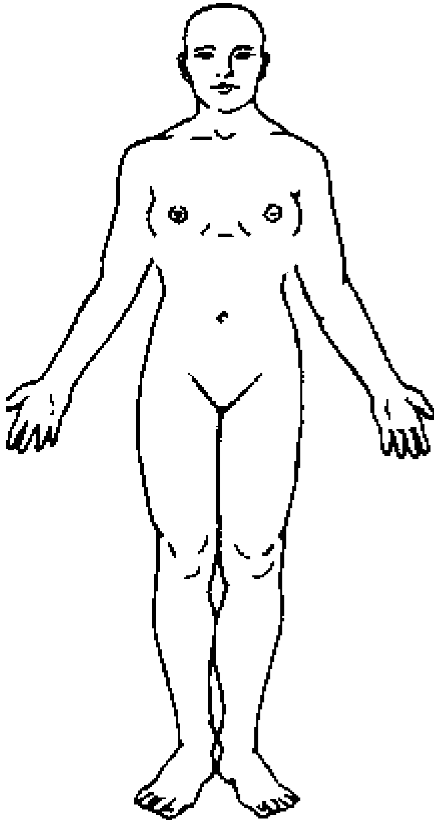
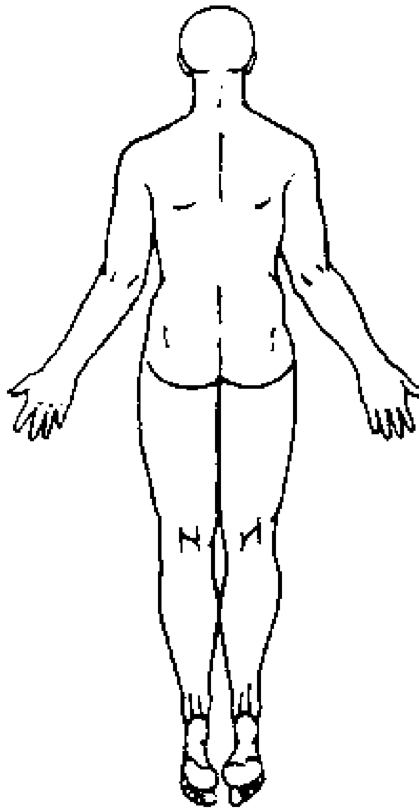
PERSONAL STATUS REPORT

Name: ______________________________ **Date:** ___________________________

Identify **current** symptomatic areas in your body by drawing the symbols on the figures below:

O – Circle areas of pain
X – "X" over areas of JOINT AND MUSCLE STIFFNESS
{ } – Draw a squiggly line along the areas of NUMBNESS OR TINGLING
ttt – Mark SCARS, BRUSISES or OPEN WOUNDS





Additional comments:
____

____

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MASSAGE THERAPY POLICY

At Sunbury Chiropractic Center, we value massage therapy as an additional therapy in our patient's care plan. We strive to provide the best therapeutic health care possible. Often, the doctor will recommend massage therapy regardless of your individual insurance coverage.

We do not bill commercial health insurance for massage. However, our therapists are licensed by the Bureau of Worker's Compensation and massage is a billable service if you are involved in a work-related injury or a motor vehicle accident. If your insurance denies payment, the amount is your responsibility.

We have a high demand for massage therapy in our office. We kindly ask you to give us a 24 hour cancellation notice if you need to cancel or reschedule your appointment. If we are not notified 24 hours prior to your appointment, we reserve the right to charge a $25 fee. Any and all massage fees will be made due prior to making any additional massage appointments. If any fees are not satisfied, we reserve the right to not schedule for your next massage appointment.

I understand that the massage/bodywork I receive is provided for the basic purposes of relaxation, stress reduction, relief of muscular tension, and therapeutic applications. If I experience any pain or discomfort during my massage, I will immediately inform the massage therapist so that the pressure and/or techniques may be adjusted to my level of comfort.

I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, chiropractor, or other qualified medical specialist if needed.

I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, or prescribe, and that nothing said in the course of the session is to be construed as such.

Because there are certain medical conditions in which massage/bodywork is contraindicated (should not be done), I affirm that I have stated all known medical conditions and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the massage therapist's part, should I fail to do so.

I have read SCC's Massage Therapy Policy and understand my responsibility for each session.

Patient Name: ____

Patient/Guardian Signature: ____Date: __________________________