

Pathway Wellness Chiropractic Clinic

Tallahassee, FL

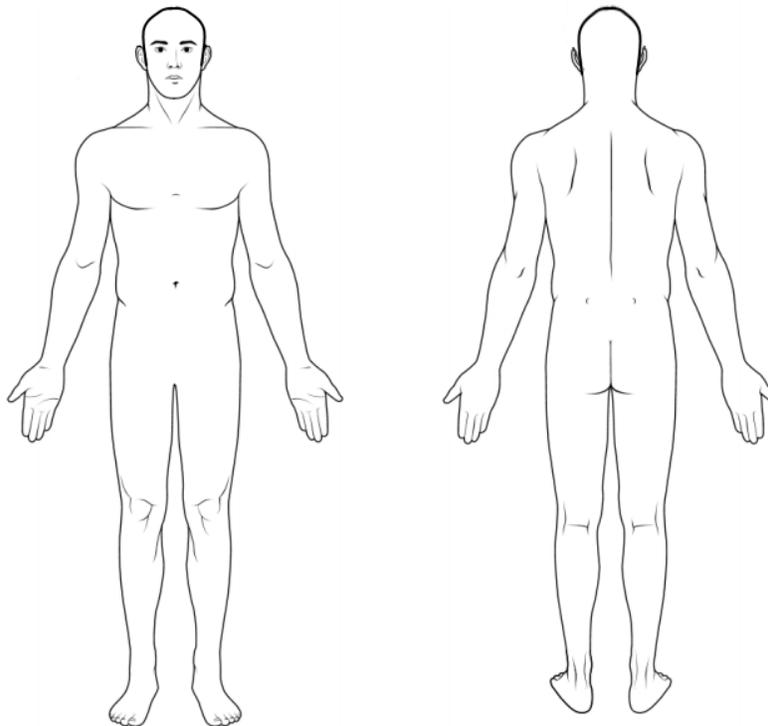
New Patient History Form

Last Name _____ First Name _____ Date _____
Last 4 of Social Security # _____ Birth Date _____
Address _____ City _____ State _____ Zip _____
Primary Phone Number: _____ Cell Phone Carrier: _____
Email Address _____
Primary Care Physician _____

Have you ever had a Massage before? _____ If Yes: Where _____
How did you respond to treatment? _____

How did you hear about our clinic? _____
What type of insurance do you have CHP Blue Cross Aetna Other _____

Please Mark Your Areas You Want Worked On Below



Are you Currently Suffering on Any of the Following:

___ Neck Pain ___ Mid Back Pain ___ Shoulder Pain ___ Headaches
___ Knee Pain ___ Foot/Ankle Pain ___ Hip Pain ___ Wrist/Elbow Pain

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Please use a **yes** or **no** when answering any of the following. If you are not sure leave a ? .

- | | |
|---|--|
| <input type="checkbox"/> Do you have a personal history of cancer? | <input type="checkbox"/> Are you Pregnant? |
| <input type="checkbox"/> Have you had any unexplained weight loss? | <input type="checkbox"/> Do you have osteoporosis? |
| <input type="checkbox"/> Recent trouble starting or stopping urination? | <input type="checkbox"/> History of prolonged use of corticosteroids? |
| <input type="checkbox"/> Recent trouble with bowel movements? | <input type="checkbox"/> Do you have a connective tissue disorder? |
| <input type="checkbox"/> Numbness in the groin region? | <input type="checkbox"/> Current or recent infection? |
| <input type="checkbox"/> Recent muscle weakness in the legs? | <input type="checkbox"/> History of immunosuppression medication &/or condition? |
| <input type="checkbox"/> History of significant trauma? | <input type="checkbox"/> Do you have hypertension? |
| <input type="checkbox"/> History of Blood Clots? | <input type="checkbox"/> Do you smoke? |
| <input type="checkbox"/> Do you have Varicose Veins? | <input type="checkbox"/> History of heart attack and/or stroke? |

CURRENT MEDICAL CONDITIONS: ie. (diabetes, high blood pressure, high cholesterol, etc)

LIST ALL MEDICATIONS/VITAMINS:

LIST ALL ALLERGIES: ie (scents, medications, food, environmental, etc)

Are you comfortable with having massage performed on the following areas? YES or NO

Gluteal Region: _____ Abdomen: _____ Chest: _____ Feet: _____ Face/Head: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Date _____

Signature of patient (or parent of minor) _____