GOODE
INTEGRATIVE HEALTH CARE

Chiropractic ~ Physical Therapy ~ Massage Therapy ~ Wellness

If you wish to receive massage therapy in our office and bill your insurance, we must have a current case history and examination on file and you must see the doctor prior to receiving massage therapy to determine the medical necessity for the therapy.

Your Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Age_____ Date of Birth:_____ Email:_____

How did you hear about our office? _____

Do you have any of the following conditions?

☐ Skin Conditions
☐ Allergies
☐ Arthritis
☐ Varicose Veins
☐ Contagious Disease
☐ Heart Disease
☐ Diabetes
☐ Asthma
☐ High Blood Pressure

Have you ever had or are you now being treated for cancer? ☐Yes ☐No

Have you ever had surgery?
If yes, please explain:

_____

_____

_____

Are you pregnant or nursing? ☐Yes ☐No

Are you currently being treated by a physician for any condition?
If yes, please explain:

_____

_____

_____

Are you wearing contacts? ☐Yes ☐No
Are you wearing dentures? ☐Yes ☐No

Are you taking any medications?
If yes, please list:

_____

_____

_____

Approximately how much water do you drink per day? _____ 8 oz. Glasses

Do you exercise regularly? ☐Yes ☐No

Describe your overall level of stress:

_____

_____

_____

All fees will be paid at the time of service, unless other arrangements have been made with the financial manager of Goode Chiropractic. Any sexual remarks, suggestions, or insinuations will not be tolerated and will result in immediate termination of your massage. You will be financially responsible for the entire scheduled time, as well as escorted from the premises. By signing below you agree to these terms and conditions.

Client
Name:_____Date:_____