Chiropractic & Massage Center
Susan Lundquist, LMT
89 West Lee Street
Hagerstown, MD 21740
301-797-3737

Date:_____
Name:_____ Email:_____
Phone:Day_____Evening_____Cell_____
Address_____City:_____ State:___Zip:_____
Age:_____ Date of Birth _____/_____/_____ M/F Martial Status_____
# of Children_____ How did you hear about us?_____
Occupation:_____ Who is responsible for payment?_____
Have you had massage therapy before? Y/N Where and by Whom?_____
What is your major area of pain or concern? _____
_____
_____
When did you first notice it?_____ What brought it on?_____
What activities aggravate it?_____
Is the condition getting worse? Y/N Does it interfere with work/sleep/recreation?
What do you believe is wrong with you? _____
What have you done to get relief? _____
Has there been a medical diagnosis? Y/N, Exam? Y/N, Blood Work? Y/N, X-Rays? Y/N
What is the diagnosis? _____
Other areas of pain or concern:
_____
_____
PAST HISTORY
Have you ever had a similar problem before? Y/N When? _____ What caused those episodes? _____ What relieved them? _____
What was the previous diagnosis? _____ What treatments? _____
Did they help? Y/N Have you had massage therapy for these conditions? Y/N If so, did it help? _____ Are you presently under a doctor's care? Y/N If so for what condition? _____
Name of Physician: _____ City: _____ State: ___ Phone: _____
Are you taking any: ( ) Medications List them _____
( ) Laxatives ( ) Sedatives ( ) Sleeping Pills ( )Insulin ( ) Blood Thinners
( ) Pain Pills (type:_____) ( ) Vitamins ( ) Herbs ( ) Minerals ( ) Birth Control Pills (} Hormone Replacement ( ) Other _____
Indicate the following habits with: H-heavy M-moderate L-light N-none
Alcohol: _____ Coffee: _____ Tea: _____ Tobacco: _____ Colas: _____ Sugared products: _____
Artificial Sweeteners: _____ White Flour Products: _____ Exercise: _____
Cravings: _____
Previous operations: _____
Previous broken bones: _____
Previous accidents or injuries: _____
Female Only – Are you currently pregnant? _____

*****PLEASE COMPLETE THE OTHER SIDE OF THIS FORM*****

PLEASE CIRCLE ANY CURRENT CONDITIONS. UNDERLINE ANY YOU HAVE HAD AS PAST PROBLEMS?

Headaches	Muscle spasms in neck	Cold sweats
Shooting pains in head	Grating in neck	Liver trouble
Sinus trouble	Tightness in shoulder muscles	Gallbladder trouble
Loss of smell	Neuritis in shoulders and arms	Indigestion
Loss of taste	Pins & needles in arms & hands	Intestinal gas
Tightness in throat	Cold hands	Constipation
Inflammation of throat	Chest pains	Kidney trouble
Thyroid trouble	Shortness of breath	Bladder trouble
Face flushed	T.B.	Diabetes
Twitching of face	Heart pain	Cancer
Loss of memory	Heart palpitations	Sleeping problems
Fatigue	Heart attack	Painful joints
Depression	High blood pressure	Swollen joints
Head feels too heavy	Low blood pressure	Arthritis
Dizziness	Anemia	Herniated or bulging disk
Fainting	Blood clots, Phlebitis	Pinched nerves in back
Loss of balance	Anemia	Pins & needles in legs
Ringing in ears	Rheumatic fever	Swollen ankles
Wear glasses	Nervous stomach	Cold feet
Light bother eyes	Stomach trouble	Pains in legs & feet
Hay fever	Ulcers	Sciatica
Asthma	Nervousness	Numb hands or feet
Epilepsy or other seizures	Inner tension	Varicose veins
Excessive perspiration	Skin disorders	Other: _____

Age of Mattress: _____ Comfortable Y/N Waterbed Y/N
Do you use a foam pillow? Y/N Do you sleep on: Side Back Stomach
Are you wearing: Heel lifts Sole supports Arch supports other: _____

Please list any allergies (medication, seasonal, topical, etc.) _____

_____

I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I also understand that I am responsible for payment if third party payment is not made. I agree to give 24 hours notice of cancellation of appointment. If less than 24 hours notice is given, I agree that the therapist may charge for the time if unable to fill the appointment with another person. Cases of extreme emergency are considered exceptions.

Signature: _____ **Date:** _____