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

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 Sweetners: _____ White Flour Products: _____ Exercise: _____
Cravings: _____
Previous operations: _____
Previous broken bones: _____
Previous accidents or injuries: _____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM.

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

Headaches
Shooting pains in head
Sinus trouble
Loss of smell
Loss of taste
Tightness in throat
Inflammation of throat
Thyroid trouble
Face flushed
Twitching of face
Loss of memory
Fatigue
Depression
Head feels too heavy
Dizziness
Fainting
Loss of balance
Ringing in ears
Wear glasses
Light bother eyes
Hay fever
Asthma
Epilepsy or other seizures
Excessive perspiration

Muscle spasms in neck
Grating in neck
Tightness in shoulder muscles
Neuritis in shoulders and arms
Pins & needles in arms & hands
Cold hands
Chest pains
Shortness of breath
T.B.
Heart pain
Heart palpitations
Heart attack
High blood pressure
Low blood pressure
Anemia
Blood clots, Phlebitis
Anemia
Rheumatic fever
Nervous stomach
Stomach trouble
Ulcers
Nervousness
Inner tension
Skin disorders

Cold sweats
Liver trouble
Gallbladder trouble
Indigestion
Intestinal gas
Constipation
Kidney trouble
Bladder trouble
Diabetes
Cancer
Sleeping problems
Painful joints
Swollen joints
Arthritis
Herniated or bulging disk
Pinched nerves in back
Pins & needles in legs
Swollen ankles
Cold feet
Pains in legs & feet
Sciatica
Numb hands or feet
Varicose veins
Other: _____

Male only:

Burning during urination
History of prostate trouble
Urination difficult or dribbling
Frequent night urination
Pain in the groin area

Female Only:

Are you presently pregnant? Y/N
How many pregnancies? _____
Pre-menstrual tension or depression
Painful menstruation-cramps
Painful breasts
Menopausal hot flashes, etc.
Form of birth control: _____
PMS: explain: _____

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: _____

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.

Date: _____ Signature: _____