CORNERstone
CHIROPRACTIC & WELLNESS

153 S Main St
Shawano, WI 54166
(715) 201-1081

MASSAGE - HEALTH SURVEY

Name: _____ Age: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip:
Email: _____ Occupation: _____

Have you experienced the following in the past few months?

- ☐ Headaches / Migraines
- ☐ Fatigue / Tired
- ☐ Fibromyalgia
- ☐ Digestive Issues
- ☐ Difficulty Sleeping
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Multiple Sclerosis
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Wrist / Hand Pain
- ☐ Elbow Pain
- ☐ Shoulder Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Dizziness
- ☐ Parkinson's Disease
- ☐ Failed Surgeries
- ☐ Ankle / Foot Pain
- ☐ Ringing in the Ears
- ☐ Nervousness / Anxiety
- ☐ Numbness / Tingling in Legs or Feet
- ☐ Numbness / Tingling in Arms or Hands
- ☐ Allergies
- ☐ Other _____

How long have you been bothered by this / these condition (s): _____
What is your current pain / symptom level on a scale 1-10 (10 being worst): _____
Please list current medications: _____
Please list recent injuries: _____
Have you had alcohol or an illegal substance in the past 48 hours? ☐ Yes ☐ No
Have you been to a Chiropractor in the past? ☐ Yes ☐ No

How does this affect your life?

- ☐ Moody
- ☐ Irritable
- ☐ Interrupt Sleep
- ☐ Restricted on Daily Activities
- ☐ Slower in Movement
- ☐ Poor Attitude
- ☐ Unable to Work Long Hours
- ☐ Lose Patience with Spouse or Children
- ☐ Restricted Household Duties
- ☐ Decreased Productivity
- ☐ Exhausted at the End of the Day
- ☐ Interferes with Ability to Participate in Desired Activities
- ☐ Hinders Ability to Exercise or Participate in Sports
- ☐ Other: _____

CHIROPRACTIC CAN POSSIBLY HELP YOU because Chiropractic doctors gently treat the body, naturally, without any drugs to remove the stress and imbalances that CAUSE health problems through a wellness approach.

Informed Consent

I have received, read and understand the policies and procedures of **Cornerstone Chiropractic & Wellness**. My massage therapist has informed me of his/her qualifications, the kind of massage services to be provided, the benefits, risks and the goals of the session(s) that we have agreed upon. I understand that I retain the right to withdraw my consent at any time during any session.

I understand that the massage services provided by **Cornerstone Chiropractic & Wellness** are intended to promote relaxation and circulation, and relieve stress, muscle tension, spasms and related pain. I understand that the massage therapy is not a substitute for medications or medical treatment and that the massage therapist does not diagnose illness nor prescribe medical treatment or perform spinal manipulations.

I have informed the therapist of my medical and physical condition and of medications I use, and I agree to update the therapist of any changes in my health profile. I release the therapist and **Cornerstone Chiropractic & Wellness** from any liability if I fail to do so.

If I experience any discomfort or pain during my session, I will immediately inform the therapist so adjustments can be made to the treatment.

EMERGENCY CONTACT: _____ **PHONE:** _____

Consent to Treat a Minor
I, the parent or legal guardian of (dependent's name) _____, authorize (therapist's name) _____ to provide massage treatments to my dependent or child.

Client Signature: _____ Date: _____