

BackFit Chiropractic & Rehab.
MASSAGE DEPARTMENT
Patient Application

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone # _____ Cell Phone # _____
Occupation _____ Date of Birth _____
E-mail Address _____ How did you hear about our office? _____

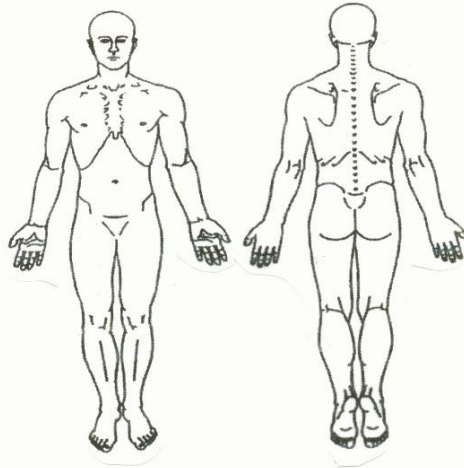
Chief complaint or reason for massage _____
Have you had a massage before? **Yes or No**
If so when was it? _____ What type was it? _____

Do you have any injuries/ surgeries that we need to know about?

Have you been in a car accident or work related accident in the last two years?

Do you ever experience any pain? **Yes or No**

If so please mark an "X" on the picture to indicate specific location.



What type of pain is it? (Please check all that apply)

- | | | | |
|---------------------------------|--------------------------------|---------------------------------|--------------------------------|
| <input type="radio"/> Sharp | <input type="radio"/> Dull | <input type="radio"/> Throbbing | <input type="radio"/> Numbness |
| <input type="radio"/> Aching | <input type="radio"/> Shooting | <input type="radio"/> Burning | <input type="radio"/> Tingling |
| <input type="radio"/> Stiffness | <input type="radio"/> Swelling | | |
| <input type="radio"/> Other | | | |

How often do you suffer from this pain? _____

Rate the pain on a scale of 1(least) to 10 (severe) _____

Does it affect your (Please check all that apply) ___ Work ___ Sleep ___ Recreation ___

Daily Routine ___ Sitting ___ Standing ___ Walking ___ Bending ___ Laying Down ___

Other _____

Patient Signature _____ **Today's Date** _____