tiburonwellnesscenter
LOVE YOUR BODY

PATIENT INFORMATION

Today's date ____/_____/_____

_____
last name first name

_____
address

_____
city state zip

_____
email

home phone (_____)_____

office phone (_____)_____

cell phone (_____)_____

_____/_____/_____ _____ ☐ male ☐ female
date of birth age

☐ single ☐ married ☐ separated ☐ divorced ☐ minor ☐ partnered

_____
occupation

_____
employer / school

_____
whom may we thank for referring you?

Have you ever received chiropractic care before?
☐ yes ☐ no

Details / Conditions treated

_____

_____

Have you ever received massage or any other type of bodywork before? ☐ yes ☐ no

Details / Conditions treated

_____

_____

Allergies? ☐ yes ☐ no
Details_____

Heart Disease? ☐ yes ☐ no

Spinal Disease? ☐ yes ☐ no

NEUROMUSCULAR THERAPY WAIVER

I, _____ understand that neuromuscular therapy given at Tiburon Wellness Center, is for the purpose of stress relief, reduction of muscular tension, spasms and/or for increasing circulation and energy flow.

I understand that the therapist DOES NOT diagnose any illness, disease, or any other physical or mental disorder. Likewise, the therapist DOES NOT prescribe and medical treatment or pharmaceuticals; nor does she perform any spinal or structural adjustments.

It has been made clear to me that this therapy is not a substitute for a medical examination and that it is recommended that I see a physician (d.c., n.d., l.ac, m.d.) for any physical aliment that I might have.

Because a therapist must be aware of existing physical conditions, I have listed below all my known medical conditions and take it upon myself to keep the therapist updated on my physical health.

Significant past or current injuries: _____

Any/All Diagnosed Conditions :_____

With all this in mind, I agree to have neuromuscular therapy at Tiburon Wellness Center, and hold the clinic and it's employees and therapist harmless for any problems that might arise as a result of my session(s).

_____ _____/_____/_____
Signature of Patient Date

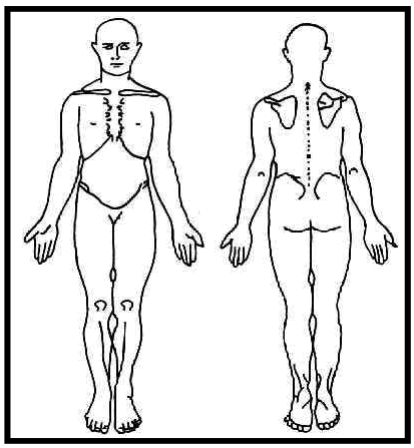
_____ _____/_____/_____
Signature of Witness Date

PATIENT CONDITION

Reason for your visit _____ When did your symptoms appear?_____

Is this condition getting progressively worse? ☐ yes ☐ no ☐ unknown

Indicate on the diagram where you are experiencing: sharp pain (xxx) aching (////)
stabbing (^^^) burning (***)
pins &needles (ooo) shooting (}}}}



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

Type of pain?

☐ sharp ☐ dull ☐ throbbing ☐ numbness ☐ aching ☐ shooting
☐ burning ☐ cramps ☐ tingling ☐ stiffness ☐ swelling ☐ other

How often to you have the pain? ☐ constant ☐ intermittent ☐ other_____

Does your condition interfere with your? ☐ work ☐ sleep ☐ daily routine ☐ recreation

Painful activities/movements to perform? ☐ sitting ☐ standing ☐ walking ☐ bending ☐ lying down

HEALTH HISTORY

What treatment have you received for your condition? ☐ none ☐ chiropractic ☐ acupuncture ☐ massage ☐ medication ☐ physical therapy

Have you ever received chiropractic care before? ☐ yes ☐ no

Name and address of other doctor(s) who have treated you for this condition_____

Date of last: physical exam_____ spinal x-ray_____ blood test _____
spinal exam _____ chest x-ray_____ urine test _____
dental x-ray _____ MRI/CT _____

Please mark "yes" or "no" to indicate if you have been diagnosed with any of the following:

AIDS/HIV	☐ yes	☐ no	diabetes	☐ yes	☐ no	measles	☐ yes	☐ no	scarlet fever	☐ yes	☐ no
alcoholism	☐ yes	☐ no	emphysema	☐ yes	☐ no	migraines	☐ yes	☐ no	stroke	☐ yes	☐ no
allergy shots	☐ yes	☐ no	epilepsy	☐ yes	☐ no	miscarriage	☐ yes	☐ no	thyroid problems	☐ yes	☐ no
anemia	☐ yes	☐ no	fractures	☐ yes	☐ no	mononucleosis	☐ yes	☐ no	TIA	☐ yes	☐ no
anorexia	☐ yes	☐ no	glaucoma	☐ yes	☐ no	multiple sclerosis	☐ yes	☐ no	tonsillitis	☐ yes	☐ no
appendicitis	☐ yes	☐ no	goiter	☐ yes	☐ no	mumps	☐ yes	☐ no	tuberculosis	☐ yes	☐ no
arthritis	☐ yes	☐ no	gonorrhea	☐ yes	☐ no	osteoporosis	☐ yes	☐ no	tumors / growths	☐ yes	☐ no
asthma	☐ yes	☐ no	gout	☐ yes	☐ no	pacemaker	☐ yes	☐ no	typhoid fever	☐ yes	☐ no
bleeding disorders	☐ yes	☐ no	heart disease	☐ yes	☐ no	parkinson's	☐ yes	☐ no	ulcers	☐ yes	☐ no
breast lump	☐ yes	☐ no	hepatitis	☐ yes	☐ no	pinched nerve	☐ yes	☐ no	vaginal infections	☐ yes	☐ no
bronchitis	☐ yes	☐ no	hernia	☐ yes	☐ no	pneumonia	☐ yes	☐ no	venereal disease	☐ yes	☐ no
bulimia	☐ yes	☐ no	herniated disk	☐ yes	☐ no	polio	☐ yes	☐ no	whooping cough	☐ yes	☐ no
cancer	☐ yes	☐ no	herpes	☐ yes	☐ no	prostate problems	☐ yes	☐ no	OTHER		
cataracts	☐ yes	☐ no	high cholesterol	☐ yes	☐ no	psychiatric condition	☐ yes	☐ no	_____	_____	
chemical dependency	☐ yes	☐ no	kidney disease	☐ yes	☐ no	rheumatoid arthritis	☐ yes	☐ no	_____	_____	
chicken pox	☐ yes	☐ no	liver disease	☐ yes	☐ no	rheumatic fever	☐ yes	☐ no	_____	_____	

EXERCISE ROUTINE ☐ none ☐ moderate ☐ daily

WORK ACTIVITY ☐ sitting ☐ standing ☐ computer ☐ lifting

HABITS
☐ smoking (packs per day) _____
☐ alcohol (drinks per week) _____
☐ coffee/caffeine(cups per day) _____
☐ high stress level (reason) _____

are you pregnant? ☐ yes ☐ no Due Date_____

current medications _____

allergies _____

vitamins / supplements _____

INJURIES / SURGERIES

	Description	date
falls	_____	_____
head injuries	_____	_____
broken bones	_____	_____
dislocations	_____	_____
surgeries	_____	_____
	_____	_____
	_____	_____
	_____	_____

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Thank you for choosing TWC as your health care choice.
Our team is committed to providing all of our patients
with the highest quality care.

Your insurance contract is a contract between you and your insurance company, not between the insurance company and TWC. **The total balance on your account is your responsibility** regardless of whether your insurance company pays or not, and **full payment is due at the time of your first visit.**

As a courtesy to our patients we will prepare and submit your insurance forms for direct reimbursement, if we accept assignment of your insurance benefits. However, you are required by law to pay your co-pay,

We require that you keep a current credit card number on file with us at all times. If your insurance company has not paid your account within 45 days, the balance will be automatically transferred to your credit card. A monthly finance charge of 1.5% will be added to unpaid balances after 60 days, accrued from the time of billing.

Unless canceled 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit.

Fees:

Half Hour Massage	$ 60
Full Hour Massage	$105
Hour and a Half Massage	$150

I have read and understood and agree to the above policy:

_____ _____
Signature of Patient/Guardian Date

_____
Name as it appears on Credit Card

_____ _____
Credit Card # for Pre-Authorization/ Expiration Date Signature of Card Holder

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