Spinal Rehab Wellness Center
Inspiring Health and Well Being

Ph: 630-236-8600, 630-708-2225
Fax: 630-236-8612
www.spinalrehabcenter.com

In order to provide you the best care possible please complete this form & bring it to your first appointment.
All information is strictly confidential.

Massage Therapy

First Name
First Name

Last Name
Last Name

Email Address
Email Address

Date of Birth
MM DD YYYY

Address Line 1
Address Line 1

Address Line 2
Address Line 2

City
City

State
State

Zip Code
Zip Code

Gender
◯ Male ◯ Female

Occupation
Occupation

How did you hear about us?

Would you like for to verify benefits for care?
◯ Yes ◯ No

If yes, what is the name of the new ins company?

Do you have insurance coverage?
◯ Yes ◯ No

Phone Numbers

Home
Home

Work
Work

Cell
Cell

In case of emergency contact

Name
Name

Relationship
Relationship

Email Address
Email Address

History

Please describe the area of complaint

Date complaint began
MM DD YYYY

How is this affecting your every day activities?

Have you had this before?
Name

Is your complaint due to
☐ Accident ☐ Injury at work ☐ Injury at home ☐ Lifting ☐ Falling ☐ Stress
☐ Auto Accident ☐ Sports Other

How long has this condition lasted?

What are my goals from treatment?

Medical Information

List any meditations you are now taking?

Medications	Allergies	Vitamins / Herbs / Minerals
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Do you have any allergies?

◯ Yes ◯ No

Please List

Are you currently under the care of a physician or psychologist?

◯ Yes ◯ No

Doctor's Name

Doctor's Name

Address

Address

Have you had any surgery since your last visit

◯ Yes ◯ No

When/Where?

Accident Information

In condition due to an accident?

◯ Yes ◯ No

Date of the Accident

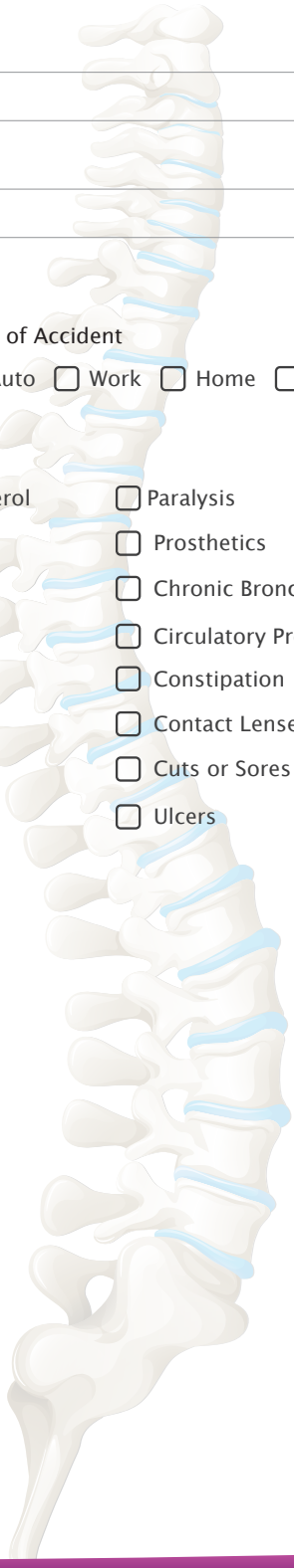
MM DD YYYY

Type of Accident

☐ Auto ☐ Work ☐ Home ☐ Other

Please Check All That Apply

☐ Autoimmune Disease	☐ Broken Bones	☐ Dizziness	☐ High Cholesterol	☐ Paralysis
☐ AIDS/HIV	☐ Burns	☐ Shoulder Pain	☐ Insomnia	☐ Prosthetics
☐ Epilepsy	☐ IUD	☐ Pregnant	☐ Arthritis	☐ Chronic Bronchitis
☐ Fatigue	☐ Joint Pain	☐ Rash	☐ Asthma	☐ Circulatory Problems
☐ Fractures	☐ Kidney Disease	☐ Sinusitis	☐ Athlete's Foot	☐ Constipation
☐ Headaches	☐ Liver Disorders	☐ Skin Problem	☐ Heart Diseas	☐ Contact Lenses
☐ Hernia	☐ Lung Disease	☐ Sciatica	☐ Back Pain	☐ Cuts or Sores
☐ Herpes	☐ Stroke	☐ Diabetes	☐ High/Low BP	☐ Ulcers
☐ Varicose Veins	☐ Bruise Easily			

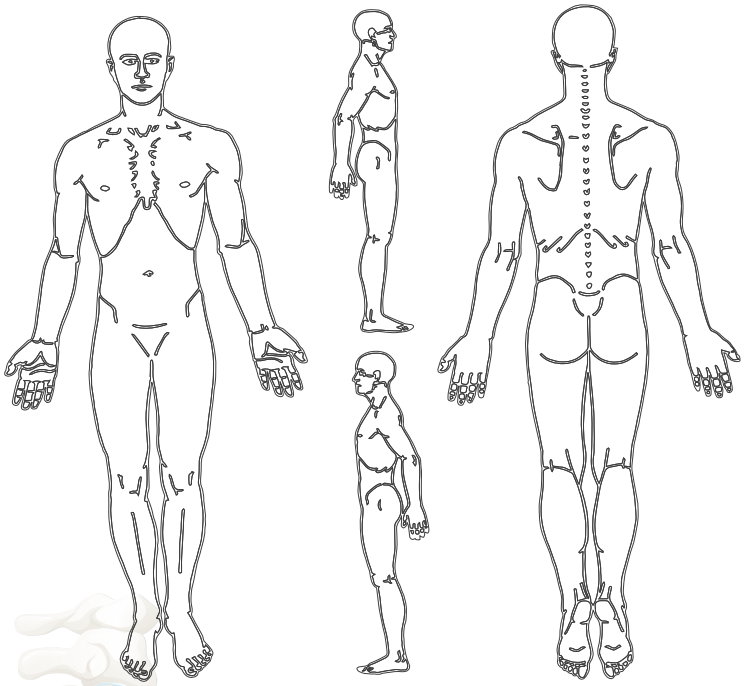


Pain Drawing

Mark an **X** on the picture where you continue to have pain, numbness, or tingling →

Key: Use Letters below to indicate type and location of Discomfort

A = Ache	B = Burning
C = Stabbing	N = Numbing
P = Pins & Needles	O = Other



I understand the therapy I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session(s), I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that soft tissue work should not be construed as a substitute for medical examination, diagnosis, or treatment. Because soft tissue work should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners fault should I forget to do so. It is also understood that any illicit or sexual suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment of the session.

Signature

Date

MM DD YYYY

(Parent/Guardian Signature required if under the age of 18)

Spinal Rehab & Wellness Center

Aurora Location

3450 Montgomery Rd, #21
Aurora IL, 60504

630-236-8600 630-236-8612

Naperville Location

2035 S. Washington Ave, #147
Naperville, IL 60565

630-708-2225 630-236-8612

Mon & Wed: 9am to 6pm | Tue & Thu: 9am to 7pm | Fri: 9am to 1pm | Sat - by Appointment