



BELDE CHIROPRACTIC & body shop

Please take just a few moments to fill out this questionnaire.
This will help us serve you better!

Today's Date _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work _____

Email address _____

Type of Employment _____ Any lifting involved? **Yes No**

Do you have health insurance? **Yes No** Name of carrier _____

Please answer the following:

1. How did you hear about our office? _____
2. Have you ever had massage or chiropractic care before? **Yes No** Did it help? **Yes No**
3. Are you presently being seen by a doctor? **Yes No**
4. Do you presently have any of the symptoms below? (Please circle any that apply)

NECK PAIN

SHOULDER PAIN

MID BACK PAIN

LOWER BACK PAIN

RADIATING LEG PAIN

LEG NUMBNESS

NUMBNESS

TINGLING

HEADACHES

BLURRED VISION

RINGING OF EARS

NAUSEA

KNEE PAIN

ANKLE OR FOOT PAIN

HIP PAIN

OTHER SYMPTOMS _____

5. Have you been involved in a motor vehicle accident within 1 year? **Yes No**
6. Have you been involved or are you treating for a work injury? **Yes No**
7. Have you been involved in any slip and fall or personal injury claim within 1 year? **Yes no**
8. Are you interested in joining The Rub Club? **Yes No**
9. Do you have any other persons you would like us to contact for a massage?

Name _____ Phone _____

Thank you for helping us serve you.
Enjoy your massage!