River City CHIROPRACTIC

Massage & Cupping Form

4311 W 6th Street, Ste C
Lawrence, KS 66049
785-856-0423

PERSONAL DATA:

Today's Date _____

Name (first middle last) _____ Preferred Name _____

Home Address _____ City _____ State _____ Zip _____

Phone (____) _____ E-mail address _____ Gender: M / F

Marital Status _____ Date of Birth _____ Race _____

Occupation _____ Employer _____

Emergency Contact _____ Primary Phone _____

Secondary Phone _____ Relation to Patient _____

Referred by _____ Family / Friend / Co-Worker / Doctor / Other

Have you ever received Massage or Acupuncture? ❑Y ❑ N
Name of Practitioner _____
How long under care? _____ Date of last visit _____ Reason for Care _____

REASON FOR SEEKING CARE:

Describe Major Complaint _____

Describe WHEN and HOW this began _____

_____

Improves Condition:
- ❑ Ice ❑ Heat ❑ Rest ❑ Movement
- ❑Stretching ❑ OTC Meds
- ❑ Other _____

Aggravates Condition:
- ❑ Sit ❑ Stand ❑ Walk ❑ Lying
- ❑ Sleep ❑ Overuse
- ❑ Other _____

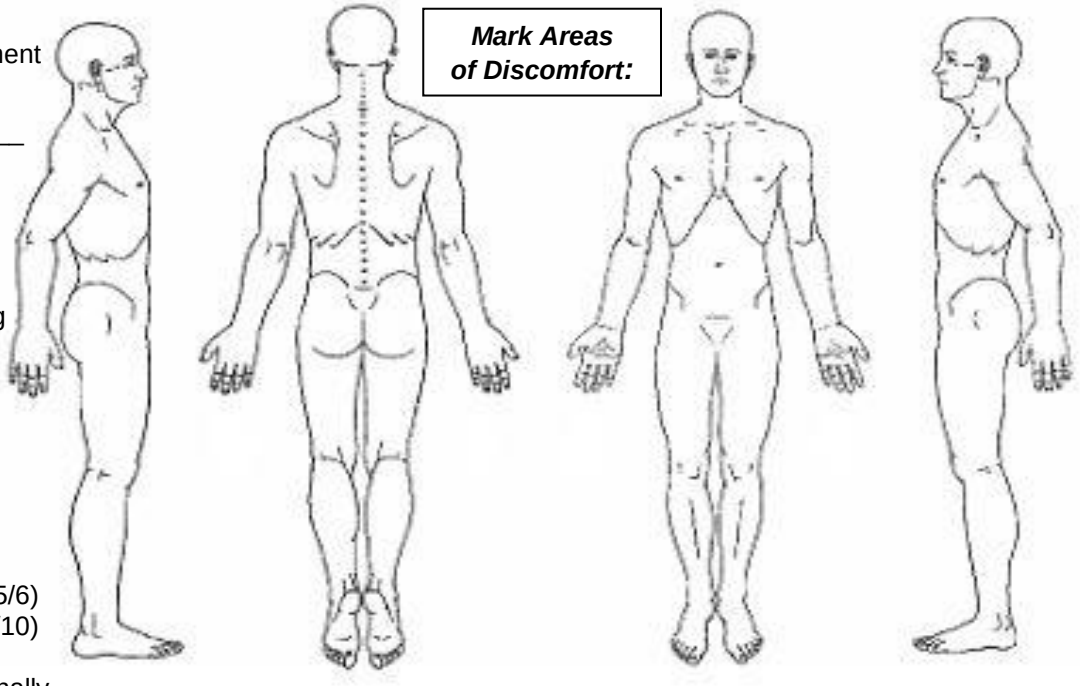
Quality of Complaint:
- ❑ Sharp ❑ Stabbing ❑ Burning
- ❑ Achy ❑ Dull ❑ Stiff & Sore
- ❑ Other _____

Does this complaint radiate/ shoot to any areas of your body? ❑ No ❑ Yes
If yes, location _____

Severity of Complaint:
- ❑ None (0) ❑Mild (1-2)
- ❑Mild-Mod (3/4) ❑ Moderate (5/6)
- ❑Mod-Severe (7/8) ❑Severe (9/10)

Frequency: ❑ Always ❑ Hourly ❑ Daily ❑Occasionally

Mark Areas of Discomfort:



Name of Medication (OTC/Rx) or Supplement	Dosage	Frequency	Method	Reason for Taking

Note: It is imperative that you list all medications as they may have an influence on your care.

Massage & Cupping Form

River City CHIROPRACTIC

REVIEW OF SYSTEMS: Check ❑C for CURRENT symptoms and ❑H for symptoms you've had a HISTORY of.

Many of these conditions respond to Chiropractic and Acupuncture treatment.

GENERAL/MIND/STRESS:
- ❑C ❑H Recent Weight Change
- ❑C ❑H Fever
- ❑C ❑H Fatigue
- ❑C ❑H Cancer
- ❑C ❑H Eating Disorder
- ❑C ❑H Alcoholism
- ❑C ❑H Nervousness
- ❑C ❑H Depression
- ❑C ❑H Sleep Problems
- ❑C ❑H Memory Loss
- ❑ *NONE IN CATEGORY*

MUSCULOSKELETAL:
- ❑C ❑H Low Back Pain
- ❑C ❑H Mid Back Pain
- ❑C ❑H Neck Pain
- ❑C ❑H Arm Problems
- ❑C ❑H Leg Problems
- ❑C ❑H Painful Joints
- ❑C ❑H Stiff/Swollen Joints
- ❑C ❑H Sore/Weak Muscles or Joints
- ❑C ❑H Muscle Spasms or Cramps
- ❑C ❑H Sciatica
- ❑C ❑H Scoliosis
- ❑ *NONE IN CATEGORY*

NEUROLOGICAL:
- ❑C ❑H Numbness or Tingling Sensation
- ❑C ❑H Loss of Feeling
- ❑C ❑H Dizziness or Light Headed
- ❑C ❑H Headaches
- ❑C ❑H Convulsions or Seizures
- ❑C ❑H Tremors
- ❑C ❑H Stroke
- ❑ *NONE IN CATEGORY*

GENITOURINARY:
- ❑C ❑H Sexual Difficulty
- ❑C ❑H Venereal Disease
- ❑C ❑H Kidney Stones
- ❑C ❑H Burning/Painful Urination
- ❑C ❑H Change of Urination force/strain
- ❑C ❑H Blood in Urine
- ❑C ❑H Prostrate Trouble
- ❑ *NONE IN CATEGORY*

GASTROINTESTINAL:
- ❑C ❑H Loss of Appetite
- ❑C ❑H Ulcers
- ❑C ❑H Digestion Problems
- ❑C ❑H Constipation
- ❑C ❑H Diarrhea
- ❑C ❑H Abdominal Pain
- ❑C ❑H Blood in Stool
- ❑C ❑H Change in Bowel Movements
- ❑C ❑H Painful Bowel Movements
- ❑C ❑H Nausea or Vomiting
- ❑ *NONE IN CATEGORY*

CARDIOVASCULAR & HEART:
- ❑C ❑H Pacemaker
- ❑C ❑H Irregular Heartbeat
- ❑C ❑H Rapid Heartbeat
- ❑C ❑H Chest Pains
- ❑C ❑H Swelling of Hands, Ankles, Feet
- ❑C ❑H Heart Problems
- ❑C ❑H Arteriosclerosis
- ❑ *NONE IN CATEGORY*

RESPIRATORY:
- ❑C ❑H Difficulty Breathing
- ❑C ❑H Persistent Cough
- ❑C ❑H Coughing Blood
- ❑C ❑H Asthma or Wheezing
- ❑C ❑H Lung Problems
- ❑C ❑H Tuberculosis
- ❑C ❑H Bronchitis
- ❑C ❑H Shortness of Breath
- ❑ *NONE IN CATEGORY*

EYES & VISION:
- ❑C ❑H Contacts or Glasses
- ❑C ❑H Blurred or Double Vision
- ❑C ❑H Eye Pain
- ❑C ❑H Glaucoma
- ❑C ❑H Eye disease or Injury
- ❑ *NONE IN CATEGORY*

SKIN AND BREASTS:
- ❑C ❑H Rash or Itching
- ❑C ❑H Change in Hair or Nails
- ❑C ❑H Breast Pain, Lump, Discharge
- ❑ *NONE IN CATEGORY*

EARS, NOSE, THROAT:
- ❑C ❑H Bleeding Gums / Mouth Sores
- ❑C ❑H Bad Breath or Bad Taste
- ❑C ❑H Dental problems
- ❑C ❑H Swollen Throat
- ❑C ❑H Voice Change
- ❑C ❑H Swollen Glands in Neck
- ❑C ❑H Ringing in Ears
- ❑C ❑H Ear Ache
- ❑C ❑H Sinus Problems
- ❑C ❑H Allergies
- ❑C ❑H Nose Bleeds
- ❑C ❑H Loss of Smell
- ❑C ❑H Hearing Loss
- ❑ *NONE IN CATEGORY*

ENDOCRINE, BLOOD, LYMPH:
- ❑C ❑H Thyroid problems
- ❑C ❑H Diabetes
- ❑C ❑H Excessive Thirst / Urination
- ❑C ❑H Cold Extremities
- ❑C ❑H Heat or Cold Intolerance
- ❑C ❑H Change in Hat or Glove Size
- ❑C ❑H Dry Skin
- ❑C ❑H Glandular or Hormone Problem
- ❑C ❑H Swollen Glands
- ❑C ❑H Anemia
- ❑C ❑H Varicose Veins
- ❑C ❑H Bruise or Bleed Easily
- ❑C ❑H Phlebitis
- ❑C ❑H Transfusion
- ❑C ❑H Immune System Disorder
- ❑ *NONE IN CATEGORY*

WOMEN ONLY:

Last Period _____
- ❑C ❑H Infertility
- ❑C ❑H Excessive Menstruation
- ❑C ❑H Cramps/Painful Periods
- ❑C ❑H Irregular Periods
- ❑C ❑H Vaginal Discharge
- ❑ *NONE IN CATEGORY*

Pregnancies:	
Date	Outcome

How do you grade your over all "Quality of Life" ❑ Good ❑ Fair ❑ Poor

How much water do you consume on a daily basis (in ounces):_____

More information regarding the above marked symptoms: _____

_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize RCC to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance to Kansas' statutes.

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

Thank you for choosing River City Chiropractic. We look forward to helping you!

Patient Name: _____