Jubilee Family Chiropractic
12844 US Hwy 431, Guntersville, AL 35976
Phone: (256) 486-3911 Fax: (256) 486-3413

PATIENT INFORMATION

Patient Legal Name: _____ Prefers to be called: _____ Today's Date: ____/____/____
Birth Date: ____/____/____ Age: _____ Gender: F M
How did you learn about us? _____ If you were referred, by whom? _____
If you are under 18 years of age, who are your legal parents or guardian?
Parent/Legal Guardian: _____ Relationship: _____
Phone (_____) _____ Date of Birth: _____
Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

Address _____ City _____ State _____ Zip _____
Phone number where we can leave a message: (_____) _____ Email _____
Name of Spouse _____ Spouse's Date of Birth ____/____/____
Who should we contact in the event of an emergency? _____ Phone (_____) _____

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Have you had a professional massage before? ☐ Yes (Date of last treatment) _____ ☐ No

List current medications and the conditions they are treating: _____
_____
_____

Please tell us about any allergies or hypersensitivities: _____
_____
_____

List any major accidents or surgeries (including dates): _____
_____
_____

Reason for initial massage: _____
_____
_____

Head/Neck
☐ Headaches/Migraines ☐ Vertigo/Dizziness ☐ Ringing in Ears ☐ Hearing Loss ☐ Vision Problems

Respiratory
☐ Asthma☐ Shortness of Breath ☐ Chronic Cough ☐ Bronchitis ☐ Emphysema ☐ Sinusitis
☐ Frequent Colds ☐ Smoker ☐ History of Respiratory Difficulties

Nervous System
☐ Sensor Loss/Change ☐ Sciatica ☐ Seizures ☐ Numbness/Tingling ☐ Epilepsy ☐Multiple Sclerosis

Musculoskeletal System
☐ Arthritis☐ Osteoporosis ☐ Bursitis ☐ Pins/Plates/Wires/Artificial Joint ☐ Family History of Arthritis
☐ Tendonitis ☐ Jaw Pain (TMJ)

Reproductive
☐ Pregnant ☐ Gynecological Problems ☐ Given Birth

Cardiovascular
☐ High Blood Pressure ☐ Heart Attack ☐ Heart Disease ☐ Phlebitis/Varicose Veins ☐ Hemophilia
☐ Chronic Congestive Heart Failure ☐ Low Blood Pressure ☐ Stroke ☐ Poor Circulation
☐ Pacemaker ☐ Family History of Cardiovascular Problems

Skin & Infections
☐ Hepatitis ☐ Herpes ☐ Lyme Disease ☐ HIV/AIDS ☐ Tuberculosis ☐ Infectious skin conditions

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Other Conditions

☐ Cancer ☐ Unexplained Weight Loss ☐ Fibromyalgia ☐ Depression ☐ Psychiatric Disorder
☐ Diabetes ☐ Digestive Conditions ☐ Chronic fatigue syndrome ☐ Anxiety
☐ Other _____
_____
_____

Disclaimer

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments will not be covered by insurance and I understand that it is my responsibility to pay for professional services when rendered.

It is our policy that payment be made at the time of each visit unless alternate payment arrangements are made.

Missed Appointment & Late Arrivals

We ask for patients to arrive at least 10 minutes before their scheduled appointment time, especially if paperwork still needs to be completed. Up to 15 minutes will be taken out of the scheduled message if late. After 15 minutes, we will need to reschedule the appointment and will charge half the amount of the service expected to be rendered.

We require at least 48 hours notice of a cancellation or change in appointment.

For missed appointments, or appointments canceled past the 48-hour notice, there will be a fee of half the amount of the service expected to be rendered at the appointment.
Having said this, we understand that emergencies sometimes occur. If there is a legitimate emergency that prevents you from keeping your appointment, please let us know and we will gladly waive this fee.

Patient Signature: _____ Date: ____/____/_____

(If patient is a minor, consent must be signed by parent or official guardian)

Parent Guardian or Legal Representative (Print Name): _____

Parent Guardian or Legal Representative Signature: _____ Date: ____/____/____