DR. L. CELIA MALMAD NPI #1730112848

CASE HISTORY

CONFIDENTIAL PATIENT INFORMATION (PLEASE ANSWER EACH QUESTION. IF THE QUESTION DOES NOT APPLY IN YOUR CASE WRITE NA FOR "NOT APPLICABLE" or UN FOR "UNKNOWN") Thank You.

DATE _____

NAME _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTHDATE _____ MARITAL STATUS: M S W D NUMBER OF CHILDREN _____

SOCIAL SECURITY NUMBER _____ MALE _____ FEMALE _____

EMPLOYER _____ ADDRESS _____

OCCUPATION _____ BUSINESS PHONE _____

SPOUSE'S NAME _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ BUSINESS PHONE _____

REASON FOR THIS APPOINTMENT: (Please list chief complaints in order of severity)

1) _____ 2) _____ 3) _____

WHO REFERRED YOU? _____

MEDICATIONS TAKEN IN THE LAST TWELVE MONTHS: _____
FOR: _____

Coffee _____ (# of cups daily) Caffeine _____ Alcohol _____ Smoker _____ (# of packs)

WHEN DID YOUR SYMPTOMS FIRST BEGIN? (The most recent flare-up) _____

HAVE YOU EVER HAD THE SAME OR SIMILAR SYMPTOMS IN THE PAST? _____

HAVE YOU BEEN UNDER CHIROPRACTIC CARE BEFORE? YES _____ NO _____ WHEN? _____

WHAT CONDITIONS WERE YOU BEING TREATED FOR? _____

NAME OF CHIROPRACTOR _____

HAVE YOU BEEN TREATED BY ANY OTHER PHYSICIANS IN THE PAST YEAR? _____

FOR WHAT CONDITION(S)? _____

HAVE YOU EVER HAD SURGERY? NO _____ YES _____ DESCRIBE _____ WHEN? _____

ACCIDENTS? (CAR, MOTORCYCLE, ETC.) _____ WHEN? _____

REGULAR EXERCISE _____ VITAMINS TAKEN REGULARLY _____

FAMILY HEALTH REPORT (please list any serious illnesses or diseases of immediate family members)

_____

_____

PATIENT'S SIGNATURE _____ PERSON RESPONSIBLE FOR ACCOUNT _____

If patient is a MINOR, signature of parent or guardian: _____

Name _____

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes: 1-never had; 2-previously had; 3-presently have.

MUSCULO-SKELETAL SYSTEM

____ Low back problems
____ Pain between shoulders
____ Neck problems
____ Arm problems
____ Leg problems
____ Swollen joints
____ Painful joints
____ Stiff joints
____ Sore muscles
____ Weak muscles
____ Walking problems
____ Ruptures
____ Broken bones

GENITO-URINARY SYSTEM

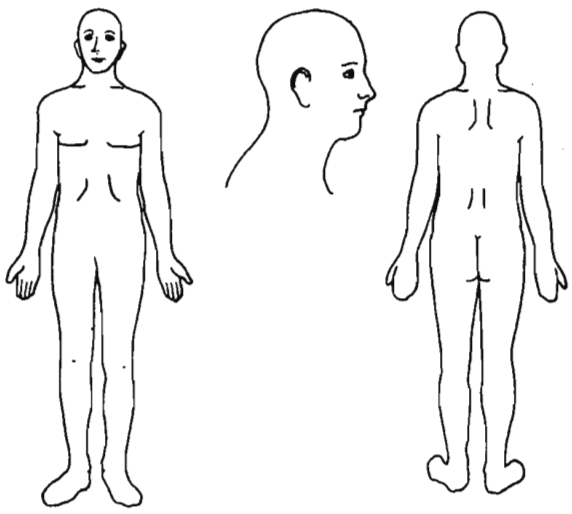
____ Bladder trouble
____ Excessive urination
____ Scanty urination
____ Painful urination
____ Discolored urine

FEMALE

____ Vaginal discharge
____ Vaginal bleeding
____ Vaginal pain
____ Breast pain
____ Lumps on breast

Are you pregnant?
____ Yes ____ No

Please mark your areas of pain on the figures below.



GASTRO-INTESTINAL SYSTEM

____ Poor appetite
____ Excessive hunger
____ Difficult chewing
____ Difficult swallowing
____ Excessive thirst
____ Nausea
____ Vomiting food
____ Vomiting blood
____ Abdominal pain
____ Diarrhea
____ Constipation
____ Black stool
____ Bloody stool
____ Hemorrhoids
____ Liver trouble
____ Gall bladder problems
____ Weight trouble

NERVOUS SYSTEM

____ Numbness
____ Loss of feeling
____ Paralysis
____ Dizziness
____ Fainting
____ Headaches
____ Muscle jerking
____ Convulsions
____ Forgetfulness
____ Confusion
____ Depression

CARDIO-VASCULAR-RESPIRATORY SYSTEM

____ Chest pain
____ Pain over heart
____ Difficult breathing
____ Persistent cough
____ Coughing phlegm
____ Coughing blood
____ Rapid heartbeat
____ Blood pressure problems
____ Heart problems
____ Lung problems
____ Varicose veins

EYE, EAR, NOSE, AND THROAT

____ Eye strain
____ Eye inflammation
____ Vision problems
____ Ear pain
____ Ear noises
____ Hearing loss
____ Ear discharge
____ Nose pain
____ Nose bleeding
____ Nose discharge
____ Difficult breathing thru nose
____ Sore gums
____ Dental problems
____ Sore mouth
____ Sore throat
____ Hoarseness
____ Difficult speech
____ Allergies
____ TMJ

CHIROPRACTIC HEALING ARTS CENTER

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC HEALING ARTS CENTER

INSURANCE INFORMATION

IF YOU WILL BE USING YOUR INSURANCE, PLEASE COMPLETE ONLY THE SECTION PERTAINING TO THE TYPE OF CLAIM INVOLVED.

_____ CHECK HERE IF YOU DO NOT HAVE INSURANCE COVERAGE (PRIVATE PAY)

A) **PRIMARY INSURANCE**

NAME OF INSURANCE CARRIER _____

ADDRESS FOR CLAIMS SUBMISSION _____

INSURED'S NAME _____ RELATIONSHIP TO PATIENT _____

INSURED'S I. D. # _____ GROUP # _____

INSURED'S BIRTHDAY _____

B) **SECONDARY INSURANCE** (Are you covered under any othe insurance plan?) _____ NO ____YES

NAME OF INSURANCE CARRIER _____

ADDRESS FOR CLAIMS SUBMISSION _____

INSURED'S NAME _____ RELATIONSHIP TO PATIENT _____

INSURED'S I. D. # _____ GROUP # _____

INSURED'S BIRTHDAY _____

C) **MEDICARE**

INSURED'S NAME _____ MEDICARE # _____

D) **WORKER'S COMPENSATION**

DATE OF INJURY _____ APPROX. TIME _____a.m. p.m.

LOCATION _____

HOW DID INJURY OCCUR? (PLEASE describe exactly what you were doing and how you were hurt.)

_____

WHEN WERE SYMPTOMS FIRST NOTICED? _____

DATE ACCIDENT WAS REPORTED _____

NAME OF SUPERVISOR ACCIDENT WAS REPORTED TO: _____

DID YOU CONTINUE WORKING?__YES__ NO ARE YOU PRESENTLY WORKING?__YES__ NO

LIST THE DATES THAT YOU WERE OFF WORK _____

OTHER DOCTORS SEEN FOR THIS CONDITION _____ WHEN? _____

WHAT WAS DONE FOR YOU? _____

E) **LIABILITY INSURANCE** (auto accident) *Plese fill out the attached accident report*

CHIROPRACTIC HEALING ARTS CENTER
P.O. BOX 299
QUAKERTOWN, PA 18951

Massage and Bodywork Intake Form

Client Information

Name _____ Date _____

Street _____ Day Phone ( ) _____

City _____ State _____ Zip _____ Eve Phone ( ) _____

Occupation _____ Date of Birth _____

Emergency Contact Name and Phone _____ ( ) _____

Referred By _____ Email _____

Massage History / Session Information

Have you ever received a professional massage? ☐ Yes ☐ No Date of last massage _____

What result do you want from your massage sessions? _____

List any exercise activities. Include frequency: _____

_____

Are you currently under the care of a health care practitioner? ☐ Yes ☐ No

If yes, specify purpose: _____

List current medications and purpose: _____

_____

Previous History (Include year and treatment received)

Injuries/accidents/illnesses still affecting you: _____

_____

Surgeries: _____

_____

Please mark any of the following that you now have or have had.

Musculoskeletal

- ☐ Bone or joint disease
- ☐ Tendonitis / Bursitis
- ☐ Arthritis / Gout
- ☐ Jaw pain (TMJ)
- ☐ Lupus
- ☐ Spinal Problems
- ☐ Other : _____

Circulatory

- ☐ Heart Condition
- ☐ Phlebitis / Varicose Veins
- ☐ Blood Clots
- ☐ High / Low Blood Pressure
- ☐ Lymphedema
- ☐ Thrombosis / Embolism
- ☐ Other : _____

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Please mark any of the following that you now have or have had. (Continued)

Respiratory

- ☐ Breathing difficulty / Asthma
- ☐ Emphysema
- ☐ Allergies specify: _____
- ☐ Sinus Problems
- ☐ Other : _____

Nervous System

- ☐ Shingles
- ☐ Numbness / tingling
- ☐ Pinched Nerve
- ☐ Other : _____

Reproductive

- ☐ Pregnant: Stage
- ☐ Ovarian / menstrual problems
- ☐ Prostate
- ☐ Other : _____

Additional Client Remarks / Comments:

_____

_____

_____

_____

Skin

- ☐ Allergies specify: _____
- ☐ Rashes
- ☐ Athletes foot
- ☐ Herpes / cold sores
- ☐ Other : _____

Digestive

- ☐ Irritable bowel syndrome
- ☐ Ulcers
- ☐ Other : _____

Other

- ☐ Cancer / tumors
- ☐ Bladder / kidney ailment
- ☐ Diabetes
- ☐ Drug / alcohol / caffeine / tobacco use
- ☐ Chronic fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Migraines / headaches
- ☐ Anxiety / stress syndrome
- ☐ Depression
- ☐ Contact lenses (hard or soft)

I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.

I understand that a massage therapist can not diagnose illness, disease, or any other medical, physical, or emotional disorder, nor perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have.

I understand that massage therapy is a therapeutic health aide and is non-sexual.

I understand that if the massage therapist starts a session late, she will make it up to me at the end of my session if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.

I agree to give 24-hour notice for a scheduled session that I can not keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

Signed _____ Date _____