Manning Wellness Clinic

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Dallas, TX 75204
PH (214) 720-2225 Fax (214) 720-2288
www.manningwellness.com

Date: _____

Name _____

Marital Status: S M D W **Date of Birth** _____**Age** _____ **M / F**

Address _____ **APT #**_____

City _____ **State** _____ **Zip** _____

Home#: (_____) _____ **Cell#: (_____)**_____ **Work#: (_____)** _____

Email Address: _____

Occupation_____ **Job Description:** _____

Spouse Name: _____ **Spouse Occupation:**_____

Emergency Contact: (Name) _____ **Relationship** _____ **Phone**_____

Have you ever received Massage Therapy? Y/N When, Where? _____

Referred By: _____

About Your Health

What is your primary reason for appointment? _____

Describe your pain/ symptoms. _____

Is this a result of injury? Describe._____

Date of injury _____

Have you ever had a massage or chiropractic care before? YES / NO Did it help? YES / NO

Please circle any of the following which apply or have applied to you:

NECK PAIN	SHOULDER PAIN	MID BACK PAIN
LOWER BACK PAIN	RADIATING LEG PAIN	LEG NUMBNESS
NUMBNESS	TINGLING	HEADACHES
BLURRED VISION	RINGING OF THE EARS	NAUSEA
KNEE PAIN	ANKLE OR FOOT PAIN	HIP PAIN

OTHER SYMPTOMS _____

Previous injuries /surgeries and dates: _____

Are you currently under a Doctor's care? YES / NO Physician's Name_____

Medications: _____

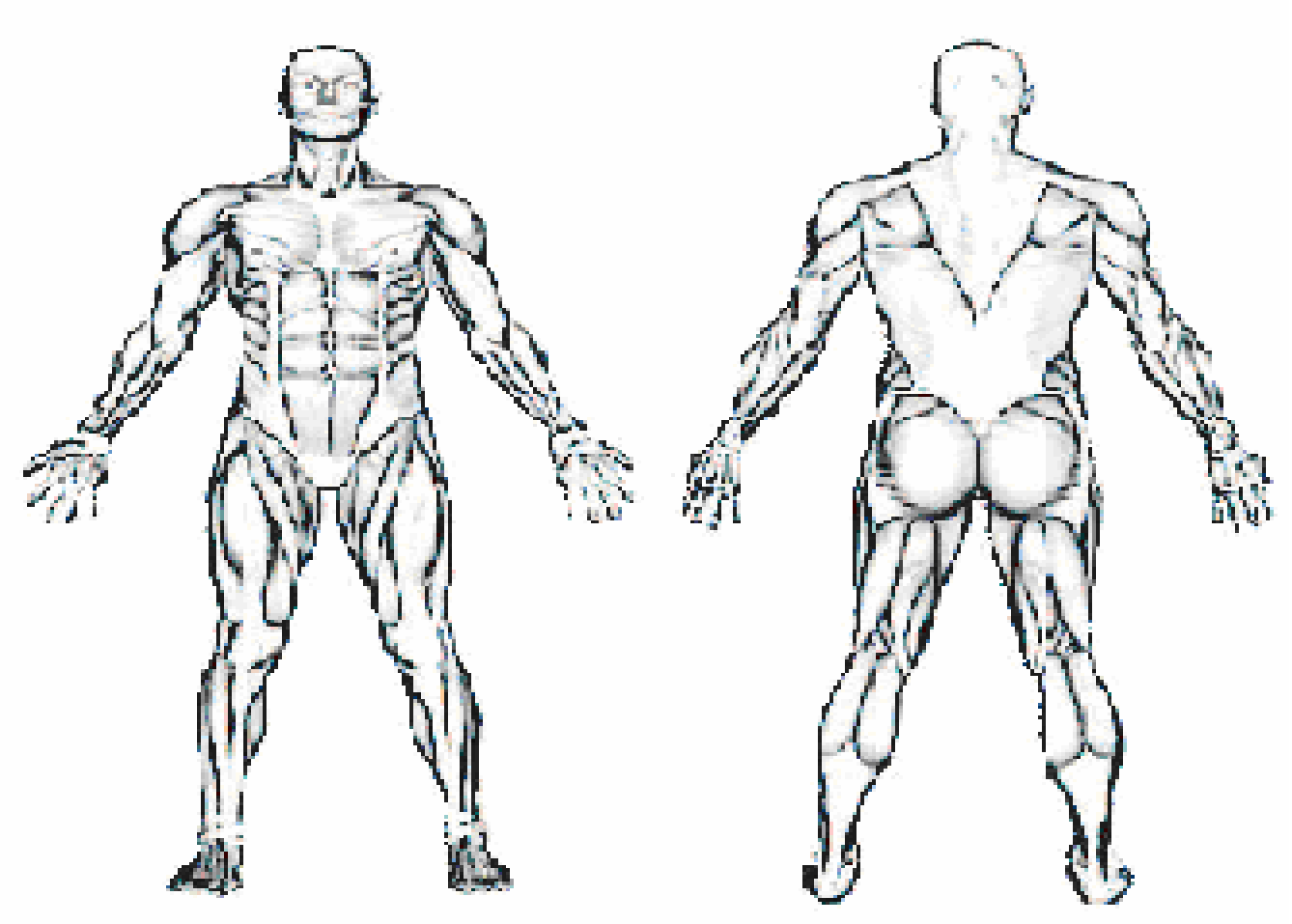
Do you exercise regularly? What type? _____

How do you sleep? (Circle all that apply) Back Stomach Side Still Restless

Where do you feel stress most often? _____

Areas to you want to be treated: _____

On the diagrams below, please circle those areas that best correspond to the places where you feel you hold stress and/or tension areas where you may be currently experiencing discomfort or pain.



_____	_____	_____
Print Client/Patient Name	Date	Therapist

I certify that all the above information is true and correct to the best of my knowledge, and that if additional medical conditions arise, I will promptly inform the therapist of those conditions. I hereby agree to be treated for the conditions and in the area indicated. I understand that no other treatment, will be initiated without my consent; and I will be appropriately draped at all times. I also understand that the treatment will be immediately terminated at my request if, at any time, I am uncomfortable.