Full Name: _____ Date: _____

Address: _____
Street City State Zip

Phone: _____ Email: _____

Date of Birth: ___ / ___ / _____ Age: _____ ☐ Female ☐ Male Pregnant? ☐ Yes ☐ No

Occupation: _____ Work Related Activities: _____

Height: _____ Current Weight: _____ Ideal Weight: _____

How did you hear about us (please circle)? Friend: (Name) _____

Google Facebook Yelp.com 5280 Magazine A List SpaFinder

Other: (please be specific) _____

Where do you rate your health right now?

Excellent Good Average Fair Poor

Which of the following services are you interested in?

Chiropractic Care Massage / Myofascial Release

Acupuncture Dry Needling / Cupping

Corrective Exercises Therapeutic Stretching / Yoga

Primary Health Concern

What brings you in today (primary health concern)? _____

_____

Rate your symptoms from 0 (no symptoms) to 10 (extremely severe):

When did your symptoms appear?

Are they getting better or worse?

Describe your symptoms:_____

_____

What prior interventions have you tried for your Primary Health Concern (medications, supplements, exercises, rest, ice, etc)? _____

_____

Anything else concerning to you about your health? _____

_____

How are you feeling today? ☐ Well ☐ Stressed ☐ Sore ☐ Depressed

☐ Other: _____

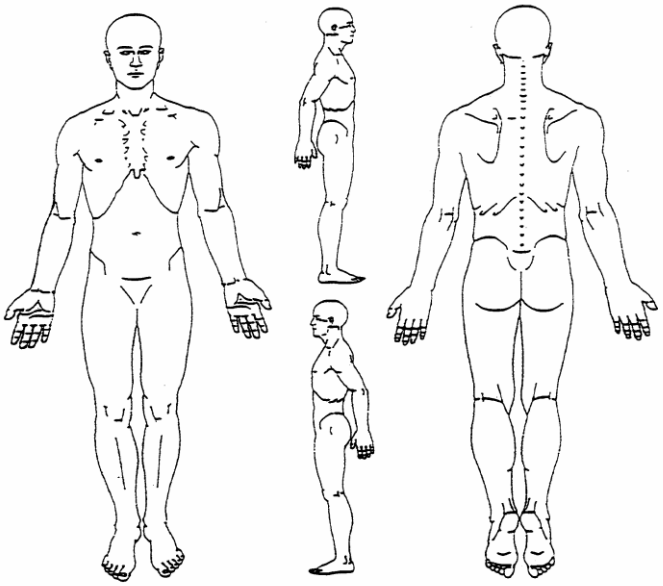
Body Work

When was your last body work session? _____

Have you tried any of the following before: (circle all) Chiropractic Care Massage Therapy

Acupuncture Dry Needling Myofascial Release Rolfing Yoga

Chinese Herbs Supplements Other: _____



Please indicate on the drawings at the left the areas that you would like your therapist to focus on today.

Please indicate any details regarding the areas of focus: (Is the pain dull and achy or sharp and shooting? Is it constant or only when you move certain directions? Worse in the morning or evening? Any recent accidents? Etc)

_____

_____

_____

_____

_____

_____

General Health and Wellness

Do you Smoke? ☐ Yes ☐ No Type: _____ Frequency: _____

Do you Drink? ☐ Yes ☐ No Frequency: _____

How much water do you drink daily? _____

What do you do to keep yourself healthy? _____

_____

Do you have any allergies (nuts, foods, seasonal, etc)? _____

_____

Medical History

Surgeries and Hospitalizations

Year	Reason
Medications	
Type	Reason

Participant Release and Knowledge of Agreement

1. I, _____, wish to participate in a wellness service offered by Moyer Total Wellness. I understand the inherent risks associated with chiropractic care, acupuncture, yoga, massage therapy, dry needling, cupping, guasha, myofascial release, and exercise. I agree to release the contractors of Moyer Total Wellness and Dr. Randal Moyer from any liability for any injuries to me resulting from participation in the wellness program (whether at Moyer Total Wellness or at home, outdoors, corporate, commercial, or other fitness facility) and I expressly release and discharge Moyer Total Wellness, it's owner, employees, contractors, from all claims, actions, judgments from any injury or other damage which may occur in connection with a wellness program.
2. I certify that the answers to the questions asked of me are true and complete. I understand and agree that it is my responsibility to inform Moyer Total Wellness of any conditions or changes in my health now and ongoing, which might affect my ability to exercise, or be treated safely and with minimal risk of injury.
3. I understand that I have the right not to perform nor participate in any activity that I do not wish to do. I understand that should I feel lightheaded, faint, dizzy, nauseated, or experience pain or discomfort, I am to stop the activity and notify emergency medical authorities.
4. I understand that the results of any wellness program cannot be guaranteed and my progress depends on my effort, consistency, and cooperation in and outside of the sessions. Wellness Specialists of Moyer Total Wellness agree to be on time and give quality and concise instruction.
5. I understand Moyer Total Wellness is a licenses health care facility and adheres to strict confidentiality regarding all medical records according to HIPAA regulations. Our patients' medical records are never obtained or released without prior written consent.
6. Moyer Total Wellness operates on a scheduled appointment basis. Thus, it is required that cancellations be made by phone or email 24 hours in advance. No charge will be assessed if calls are made 24 hours before the appointment time. However, should I cancel within 24 hours; I will be charged in full for that session. I understand that Moyer Total Wellness recommends that all cancelled sessions be rescheduled to ensure consistency of wellness process.
7. I understand that during a session, Doctors of Chiropractic, Rolfers, Acupuncturists, massage therapists, personal trainers, and/or other providers may have to use physical touch to perform treatment. If I feel uncomfortable or experience any type of discomfort with being physically touched, I will immediately request to discontinue the treatment.
8. I understand it is my responsibility to inform providers of potential pregnancy. I understand that some treatments such as Chinese herbs, supplements, massage therapy, vigorous exercise may cause risk during pregnancy.

I have read this Release of Terms of Agreement and I understand all of its terms. I sign it voluntarily and with full knowledge of its significance.

_____ _____

Client or Parent (Signature) Date

If the patient is a minor, print child's name in full: _____

Please check all that apply (past or present conditions):

Musculoskeletal

- ☐ Arthritis
- ☐ Neck Pain
- ☐ Poor Posture
- ☐ Elbow/Wrist Pain
- ☐ Headaches
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Hip/Leg Pain
- ☐ Back Pain
- ☐ Disc Injury
- ☐ TMJ Issues
- ☐ Foot/Ankle Pain
- ☐ Rheumatoid
- ☐ Knee Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Other: _____
- ☐ None

Neurological

- ☐ Dizziness
- ☐ Migraines
- ☐ Numbness/Tingling
- ☐ Other: _____
- ☐ None

Cardiovascular

- ☐ Stroke
- ☐ Blood Clots
- ☐ Circulation/Bruising
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Other: _____
- ☐ None

Respiratory

- ☐ Asthma
- ☐ Sleep Apnea
- ☐ COPD
- ☐ Other: _____
- ☐ None

Digestive

- ☐ Acid Reflux
- ☐ Ulcer
- ☐ Heart Burn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Food Sensitivities
- ☐ Nausea
- ☐ Bloating
- ☐ Stomach Pain/IBS
- ☐ Other: _____
- ☐ None

Sensory

- ☐ Ringing in Ears
- ☐ Hearing Loss
- ☐ Ear Infections
- ☐ Loss of Taste
- ☐ Loss of Smell
- ☐ Blurred/Lost Vision
- ☐ Other: _____
- ☐ None

Constitutional / Other

- ☐ Fainting
- ☐ Fatigue
- ☐ Appetite Changes
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Cancer
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Insomnia
- ☐ Infertility
- ☐ Other: _____
- ☐ None

Has any member of your family had any of the above? If yes, who and what? Please explain:

_____

_____

Is there anything else our healthcare providers should know about you? _____

_____

_____

_____