HUDSON VALLEY WELLNESS CENTER

DR. THOMAS P. ZWART, CHIROPRACTOR
EMILIE E. ZINSER, MASSAGE THERAPIST
103 Maple Avenue, Rt 302, Pine Bush NY 12566

Patient/Client's name_____ DOB_____ Sex_____
Address_____ City _____ State_____ Zip_____
Home Phone _____ Cell_____ SS # _____
E-MAIL _____ Occupation _____
Employer _____ Employer Address _____
Work Phone _____
Marital Status M___ S___ W___ D___ Spouse's Name _____
Spouse's Occupation _____ Employer _____
Emergency Contact _____ Phone # _____
Primary Care Physician _____ Phone # _____

Name of Insured _____ Spouse's SS# _____ DOB _____
Insureds Address (if different from patient's) _____
Name of Insurance Company_____ Address_____
Is your condition work related or due to auto accident? _____
What is your Major Health Complaint? _____
_____
_____
List Doctor's seen for this Condition: _____

If here for Massage, is it for a medical condition, injury, or surgery? _____
Have you ever received professional massage/bodywork before? _____ How recently? ____
What types of Massage do you prefer? Light Medium Firm
What are your goals/expected outcomes of treatment at our office? _____
_____
_____

Were you referred to this Office? _____ By Whom _____

Please Read and Sign the Following:
I hereby authorize you to furnish all information concerning my condition while under your care including history obtained, x-ray and physical findings, diagnosis and prognosis, as requested.

I understand that I am personally responsible for payment for all services rendered to me. Payment is due at each visit, unless other prior arrangements have been made.

Patient/Client's Signature _____ Date _____
Guardian or Spouse's Signature _____ Date _____
(Authorizing Care)

PLEASE, IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, GIVE THE OFFICE 24 HOUR NOTICE. THANK YOU

WHAT TYPE OF REGULAR EXERCISE DO YOU PERFORM? _____

HEIGHT _____ WEIGHT _____

PLEASE PLACE A CHECK BY ANY CONDITION THAT PERTAINS TO YOU; PAST & PRESENT:

Headache	**_____**	**Pacemaker**	**_____**
Neck Pain	**_____**	**Heart Attack**	**_____**
Upper Back Pain	**_____**	**Chest Pain**	**_____**
Mid Back Pain	**_____**	**Stroke**	**_____**
Low Back Pain	**_____**	**Easily Bruise**	**_____**
Shoulder Pain	**_____**	**Varicose Veins**	**_____**
Elbow/Upper Arm/Hand/		**High Blood Pressure**	**_____**
Wrist Pain	**_____**	**Kidney Stones/Disorders**	**___ _**
Lower Extremity Pain	**_____**	**Bladder Infections**	
Broken Bones	**_____**	**Painful Urination/Frequent**	**_____**
Scoliosis	**_____**	**Loss of Bladder Control**	**_____**
Joint Swelling/Stiff	**_____**	**Prostate Problems**	**_____**
Arthritis	**_____**	**Thyroid Condition**	**_____**
Rheumatoid Arthritis	**_____**	**Abnormal Wt. Gain/Loss**	**_____**
Auto Immune Disease	**_____**	**Loss of Appetite**	**_____**
Fatigue	**_____**	**Ulcer**	**_____**
Muscular In-coordination	**_____**	**Hepatitis A B C**	**_____**
Visual Disturbances	**_____**	**Liver/Gall Bladder**	**_____**
Dizziness/ringing in ears	**_____**	**Gas/Bloating/Constipation**	**_____**
Epilepsy/Seizures	**_____**	**Cancer/Tumor/Kind?**	**_____**
Memory Loss/Confusion	**_____**	**Asthma/Shortness of Breath**	**_____**
Diabetes	**_____**	**Chronic Sinusitis**	**_____**
Excessive Thirst	**_____**	**Allergies**	**_____**
Drug/Alcohol Use	**_____**	**Dermatitis**	**_____**
Smoke?	**_____**	**Eczema/Rash**	**_____**
Clinical Depression	**_____**	**Birth Control Pills**	**_____**
HIV/Aids	**_____**	**Pregnancy**	**_____**
Wear Contacts	**_____**	**Sensitivity to Touch**	**_____**

Surgical History _____
List all Medications (including vitamins)_____
_____

Family Health Information:

Name	**Relationship**	**Past & Present Health Problems**
_____	_____	_____
_____	_____	_____
_____	_____	_____