

Back-2-Wellness PA

Massage • Chiropractic • Wellness

Patient Information Sheet

Last Name: _____ First Name: _____ Middle Initial: _____

Date Of Birth: _____ Age: _____ Social Security#: _____

Do you have Health Insurance? _____ What company? _____

Are you Pregnant? _____ Do you have Medicare or Medicaid coverage? _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail (Back-2-Wellness will not share this information): _____

Address: _____

City: _____ State: _____ Zip Code: _____

How did you hear about us? _____

Have you been to a Chiropractor before? _____ How long ago? _____

Have you had a massage before? _____ How long ago? _____

Are you aware of any reason you should not be manipulated or have therapy? _____

If so, please explain _____

In case of an emergency, who should we contact?

Name: _____ Phone: _____

Secondary Phone #: _____

Relation to you: _____

May we discuss your condition with this person? _____