KEYSTONE CHIROPRACTIC
Associates of Newnan, LLC.

# *General Neuromuscular Therapy & Massage Therapy Client Information Questionnaire*

Thank you for choosing Keystone Chiropractic Associates for your care. It is our mission to provide patients and clients with the highest quality primary holistic musculoskeletal healthcare.

By completing the requested information you will better assist us in being able to determine the course of appropriate care for your particular health concerns. Feel free to complete this questionnaire at your convenience prior to your visit with us and simply bring it with you to your confirmed appointment. If you have already completed this form for chiropractic care (and we have a copy of it in your records), you do not need to submit this additional information. If you have any questions, feel free to contact our office at 678-673-6552.

***Office Use Only:***
*P File#:*_____
*R File#*_____

KEYSTONE CHIROPRACTIC
Associates of Newnan, LLC.

# General Client Information

*(To be completed by patient or legal guardian and returned to the receptionist)*

Please Print:
Today's date: _____ Date of Birth: _____ Age: _____

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

Sex: ____ Male ____ Female

Is there another name that you prefer to be called?: _____

Are you seeking care due to an auto accident or job-related injury? ☐ Yes ☐ No

Home Address *line 1:* _____

Home Address *line 2:* _____

Home City: _____ State: _____ Zip: _____

Phone: H: _____ W: _____ C: _____

Email: _____

Occupation: _____ Employer: _____

Work Address line 1: _____

Work Address line 2: _____

Work City: _____ State: _____ Zip: _____

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone: _____

***Office Use Only:***
*P File#:*_____
*R File#*_____

KEYSTONE CHIROPRACTIC
Associates of Newnan, LLC.

# General Client Information

*(PAGE 2)*

Have you Received Neuromuscular Therapy or Massage Therapy in the past?: ☐ Yes ☐ No

Is there anything that you did not like about your past Massage Therapy experience?:

_____

_____

_____

What is your primary reason for seeking Neuromuscular Therapy/ Massage Therapy now? _____

_____

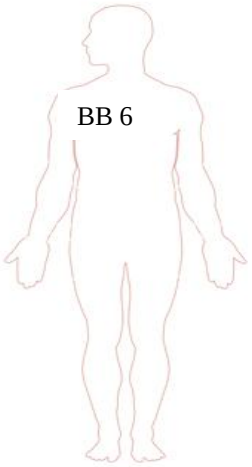
_____

_____

***Using the following diagrams, please indicate the area(s) of injury or discomfort that you are seeking care for:*** (For each area, indicate the level of discomfort on a scale of 1-10; 1= very mild/barely noticeable and 10=unbearable) (See example below)

NN Numbness
PP Pins & Needles
BB Burning
AA Aching
SS Stabbing

Example: burning feeling in the right chest that is 6/10 in pain
**Front**



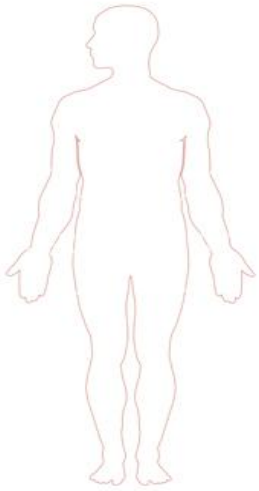
***Office Use Only:***
*P File#:*_____
*R File#*_____

KEYSTONE CHIROPRACTIC
Associates of Newnan, LLC.

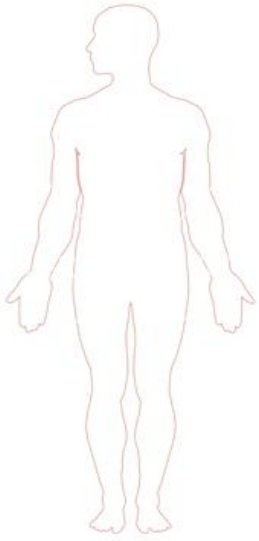
# General Client Information

*(PAGE 3)*

**Your Front**



**Your Back**



***Office Use Only:***
*P File#:*_____
*R File#*_____

KEYSTONE CHIROPRACTIC
Associates of Newnan, LLC.

# General Client Information

*(PAGE 4)*

By signing this application, you agree that 1) you are consenting to delivery of professional neuromuscular therapy and/or massage therapy care, 2) that you are the individual represented by, or the legal guardian for the individual represented by the information above, 3) the information that you have provided above is current and accurate to the best of your knowledge and that no intentional omissions or falsifications have been completed, and 4) you are the responsible party for all charges and financial responsibilities incurred for services provided.

Additionally, by signing below, you affirm that your request for neuromuscular therapy and massage therapy is not due to current or pending litigation.

_____ Client Name

_____ Name of legal guardian (if client is a minor)

_____ Signature of Client (or legal guardian)

_____ Date Signed

GNMTIF 101512