Michael R. Burris,CNMT
1332 Linden
Longmont, CO 80501
303-596-3277

PATIENT INFORMATION

Patient ______________________________ Age_____ Birth date_________ M__ F__
Marital Status: S M W D Name of spouse, if married ____________________ Home Phone________________
Name of Patient, if patient is a child______________________________
Address______________________________City____________State________Zip________
Employer______________________________Telephone#______________________
Employer's Address______________________________City____________State________Zip________
If refereed, by whom? ______________________________
Person responsible for payment______________________________
Relationship to Patient______________________Address______________________________
City____________ State_____ Zip Code____________ Social Security #______________________
Employer and address______________________________
In case of an emergency please notify: Name______________________________
Address______________________Telephone______________________________
Relationship______________________

MEDICAL HISTORY

Have you ever had problems with any of the following? Please describe briefly.

___Allergies______________________ ___Surgery______________________
___Heart trouble______________________ ___Varicose veins or blood clots______________________
___Chest pains______________________ ___Skin related problems ______________________
___High blood pressure______________________ ___Diabetes______________________
___Swelling in joints______________________ ___Previous therapy or chiropractic______________________
___Arthritis______________________ ___Any serious illness not listed ______________________
___Cancer______________________ ______________________
___Epilepsy, convulsions or fainting spells______________________ ___Other______________________

Are you presently taking medication of any kind? ______________________________
Are you presently under a physician's care? ______________________________
Are you pregnant? ______________________________
Do you bruise easily? ______________________________
Have you received massage therapy in the past? ______________________________
Comments: ______________________________

CANCELLATION POLICY

If you need to cancel an appointment, kindly do so at least 24 hours in advance so that someone else may fill your time. **All no call-no show appointments are kindly asked to pay for the missed appointment.**

I have read the Cancellation Policy, understand and agree to it by signing below.

X____ Date______________
Signature of patient or responsible party