The Muscle Repair Shop

Live pain free!

REGISTRATION FORM

(Please Print)

Today's Date:	

PATIENT INFORMATION

Patient's last name: H **First:** **Middle:**	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	**Marital status:** Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐
Email Address: _____	_____	**Birth date:**	Sex: ☐ M ☐ F
Street address:			**Home phone no.:** ( )
P.O. Box:	**City:**	**State:**	**ZIP Code:**
Occupation:	**Employer:**		**Employer phone no.:** ( )
Chose clinic because/referred to clinic by (Please check one box):	☐ **Dr.** _____		
☐ Family ☐ Friend ☐ Close to home/work	☐ Advertisement	☐ Other _____	
Other family members seen here:			

REASON FOR VISIT

_____

_____

What makes your condition worse?

_____

_____

Any surgeries in the last 4 years?

_____

_____

Do you suffer from any of the following conditions:

Heart Condition_____ Sciatic Pain _____ High Blood Pressure _____ Low Blood Pressure _____ Arthritis _____

Headaches _____Diabetes _____ Cancer _____ Leg/foot Pain _____ Allergies _____ Vascular/Blood Disorders _____

Herniated/Bulging Discs _____Neuropathies _____ Edema/Swelling _____ Neck/shoulder Pain _____

What medications are you currently taken?

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:** ( )	**Work phone no.:** ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize The Muscle Repair Shop to treat my condition.

Patient/Guardian signature **Date**

Just type your name for your signature if online.