

Welcome!

Today's Date: _____

Basic Information:

Last Name _____ First Name _____

Address _____ Address 2 _____

City _____ State _____ Zip _____ DOB _____ M/F _____

Home Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____

Work Phone _____ - _____ - _____ Ext _____

e-mail _____ (we NEVER share or sell your e-mail)

Would you like receive e-mail offers and information on: Chiropractic? Massage? Nutrition?

Referred By: _____ Occupation: _____

Massage History:

Have you had a professional massage before? _____ When was your last one? _____

Do you get regular massage? _____ How often? _____

Confidential Health History/Assessment:

Do you exercise regularly? _____ If yes, what type(s)? _____

Please check any that apply:

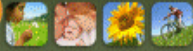
- | | | |
|--|---|--|
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Contagious Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dentures | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Swelling/Bloating/Edema | <input type="checkbox"/> Pregnant (Trimester _____) | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Nursing | <input type="checkbox"/> Sharp Pains |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Chronic Pain Disorder (i.e. Fibromyalgia) |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Cardiac/Circulatory Problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> TMJ | <input type="checkbox"/> Spine Problems (scoliosis etc...) |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Smoker | <input type="checkbox"/> Drink Alcohol | <input type="checkbox"/> Thyroid Dysfunction |
| <input type="checkbox"/> Skin Conditions (eczema, acne, open sores etc...) | <input type="checkbox"/> Other Joint Disorders/Joint Pain (tendonitis, bursitis, etc..) | |

Allergies | Please Specify

Recent Injury/Accident

Past or Current Major Illnesses (Cancer, AIDS etc...)

Medications:



Please Indicate Below any areas you are having trouble with:

A=Ache

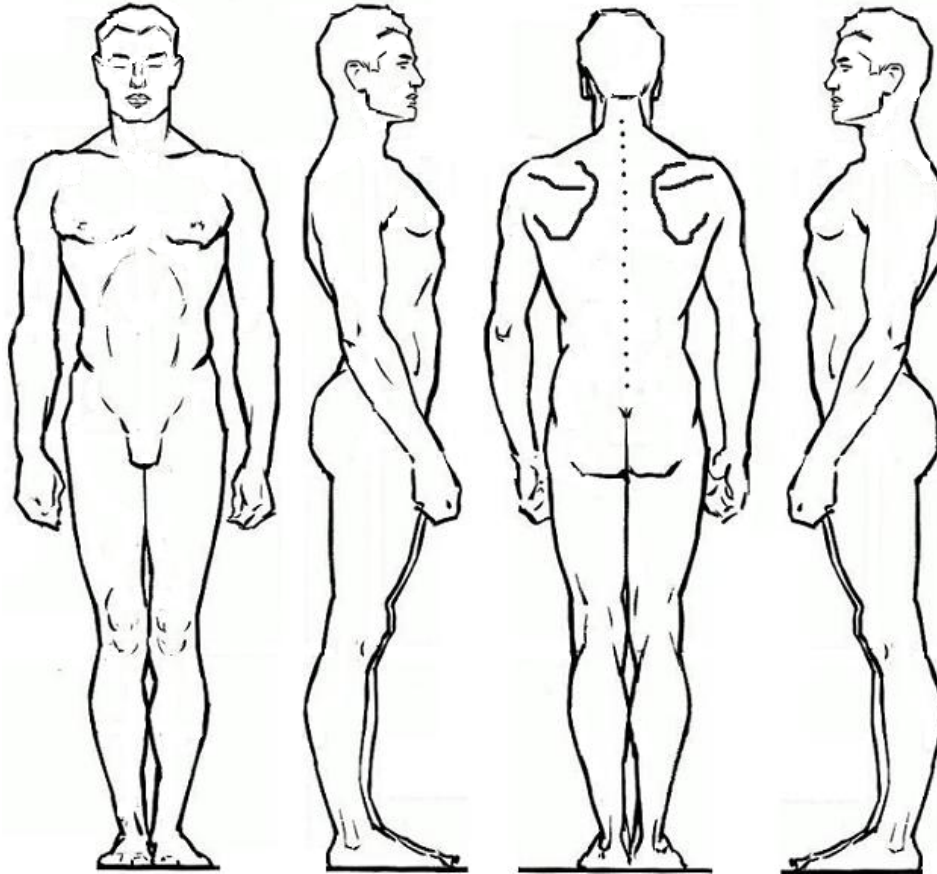
B=Burning

N=Numbness

P=Pins & Needles

S=Stabbing

O=Others



Use this space to mention any other issues or concerns:

Consent for Care:

- ✓ It is my choice to receive Massage Therapy, and I give consent to receive treatment.
- ✓ I understand that Massage Therapists DO NOT diagnose illness, disease or any other physical or mental disorders, and that Massage Therapy is not a substitute for medical examination and/or diagnosis.
- ✓ I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my physical and mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so.
- ✓ I agree that If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.
- ✓ I understand that Massage is for Therapeutic purposes and no inappropriate sexual conduct will be tolerated.

Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____