Advanced Chiropractic Clinic

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MASSAGE THERAPY
HEALTH HISTORY AND MEDICAL INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Employer: _____ Job Title: _____

How did you hear about us? _____
(Please be specific – If a person referred you here, we'd like to thank them)

Have you had a massage before? _____

Do you have concerns about receiving massage? _____
(If yes, please Explain)

What would you like most from your session today? _____

Please list any Chronic Conditions or health concerns: _____
_____

Please list any Injuries/ Auto Accidents/ Surgeries with dates: _____
_____

Do you have any allergies to oils, lotions, ointments, fruits or nuts? Yes / No
If yes, please explain _____

Do you have sensitive skin? Yes / No

What is your activity level? _____
_____

I agree to pay for missed appointments if I do not give at least a 24 hour cancellation notice.

X_____
Signature/Date

Medical History

Do you currently or have you ever had any of the following: (please check)

_ Phlebitis
_deep vein thrombosis/blood clots
_ Joint disorder
_ rheumatoid arthritis/osteoarthritis/tendonitis
_ Osteoporosis
_ Epilepsy
_ headaches/migraines
_ Cancer
_ Diabetes
_ decreased sensation
_ back/neck problems
_ Fibromyalgia
_ TMJ
_ Carpal tunnel syndrome
__contagious skin condition
__open sores or wounds

__tennis elbow
__recent fracture
__recent surgery
__artificial joint
__sprains/strains
__current fever
__swollen glands
__allergies/sensitivity
__heart condition
__high or low blood pressure
__circulatory disorder
__varicose veins
__atherosclerosis
__easy bruising
__recent accident or injury
__pregnancy, how many months?__

Are you currently under medical supervision? Yes No
If yes, please explain_____

Do you see a chiropractor? Yes No If yes, how often?_____

Are you currently taking any medication? Yes / No
If yes, please list

_____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you?

_____
_____
_____

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions,
I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____