mind, body & spirit chiropractic

Massage Client Information Form

Name:		Birth Date:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Occupation:	Job Duties:	
Primary Care Physician:		Phone:
In case of an emergency, please contact:		Phone:

Who can we thank for referring you to our office: ❑ Newspaper ❑ Mail ❑ Sign ❑ Yellow Pages ❑ Referral_____ ❑ Other_____

Massage History/Session Information

Have you ever received a professional massage? ❑ Y ❑ N Date of last massage: /

My goal for my massage session today is :

❑ To relax ❑ To get work on a specific area

❑ To help relieve a health concern ❑ To experience a therapeutic massage

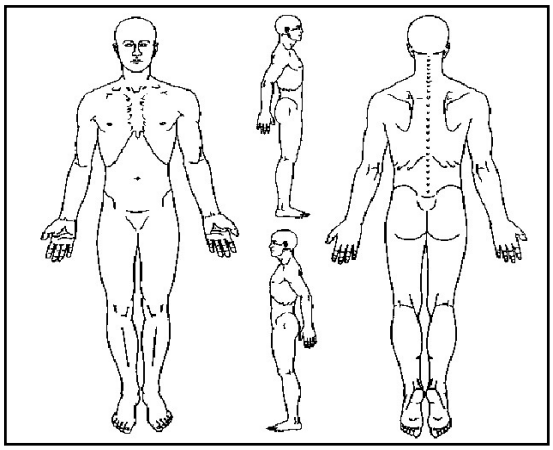
❑ Other:

Are you currently under the care of a health practitioner? ❑ Y ❑ N

If yes, specify purpose:

List current medications and purpose:

I feel the pressure that would best fit my needs would be:
❑ Very/light/light ❑ Medium ❑ Deep/Heavy ❑ I don't know
**The therapist will always work within your tolerance level. It is your responsibility to tell him/her if the pressure is/isn't correct for you.*



Please indicate any area of tension or soreness that you would like to massage therapist to address specifically.

Please circle or "X" the area to the left.

Prioritize ONLY specific problem areas:

(1-High Priority, 2-Secondary, 3– If we have time)

_____Neck
_____Legs
_____Hands

_____Upper Back
_____Lower Back
_____Upper Chest
_____Face/Scalp

_____Hip
_____Arms
_____Feet

Are you on prescription blood thinners? ❑ Y ❑ N

Do you suffer from blood clots? ❑ Y ❑ N

(Continue to Next Page)

*** For consideration to our other patients and Valerie, please give at least 24 hours notice to cancel/reschedule your appointment to avoid any incurring charges

ABOUT YOUR HEALTH

The human body is designed to be healthy. At Mind, Body & Spirit Chiropractic, we are dedicated toward achieving the goal of total lasting health for our members. To better help us achieve this, we need to understand your complete health history. Please help us help you by taking a few moments to answer the following questions.

PRESENT HEALTH CONDITIONS

Please mark any of the following that you now have or have had.

Musculoskeletal

- ❑ Bone or joint disease
- ❑ Tendonitis/Bursitis
- ❑ Arthritis/Gout
- ❑ Jaw Pain (TMJ)
- ❑ Lupus
- ❑ Spinal Problems
- ❑ Other: _____

Skin

- ❑ Allergies
- ❑ Rashes
- ❑ Athletes foot
- ❑ Herpes/cold sores
- ❑ Other: _____

Digestive

- ❑ Irritable Bowel Syndrome
- ❑ Ulcers
- ❑ Other: _____
- ❑ Other: _____

Circulatory

- ❑ Heart Condition
- ❑ Phlebitis/Varicose Veins
- ❑ Blood Clots
- ❑ High/Low Blood Pressure
- ❑ Lymphedema
- ❑ Thrombosis/Embolism
- ❑ Other: _____

Nervous System

- ❑ Shingles
- ❑ Numbness/Tingling
- ❑ Pinched Nerve
- ❑ Other: _____

Reproductive

- ❑ Pregnant: Stage_____
- ❑ Ovarian/Menstrual Problems
- ❑ Prostate
- ❑ Other: _____

Respiratory

- ❑ Breathing Difficulty/Asthma
- ❑ Emphysema
- ❑ Allergies
- ❑ Sinus Problems
- ❑ Other: _____

Other

- ❑ Cancer/Tumors
- ❑ Bladder/Kidney ailment
- ❑ Diabetes
- ❑ Drug/alcohol/caffeine/tobacco use
- ❑ Chronic fatigue
- ❑ Chronic pain
- ❑ Sleep disorders
- ❑ Migraines/Headaches
- ❑ Anxiety/Stress Syndrome
- ❑ Depression
- ❑ Contact lenses (hard or soft)

INFORMED CONSENT

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes can be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal 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/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.

Client Signature_____ Date: _____

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Please mark each item below for each sign or symptom you currently have or previously had:
Mark "C" for current Mark "P" for past Current = within the last 3 months

CONSTITUTIONAL
__ Weight Loss
__ Weight Gain
__ Decrease Energy
__ Increase Energy
__ Difficulty Sleeping

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Osteoporosis
__ Joint Replacement
__ Herniated Disc
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Muscle Weakness
__ Sprains/Strains
__ Broken Bones
__ Gout
__ Fibromyalgia
__ Arthritis

CARDIOVASCULAR
__ High Blood Pressure
__ Heart Attack
__ Chest Pain
__ Poor Circulation
__ Heart Disease
__ Irregular Heartbeat
__ Jaw pain
__ Aortic Aneurism
__ Swelling Ankles
__ Varicose Veins
__ High Cholesterol
__ Pacemaker/Defibrillator

EAR/EYE/NOSE/THROAT
__ Ear Noises
__ Dizziness
__ Sore Throat
__ Hearing Loss
__ Nasal Blockage
__ Nose Bleeds
__ Glaucoma
__ Sinusitis
__ Difficulty Swallowing
__ Bleeding Gums
__ Double Vision
__ Blurred Vision

GASTRO-INTESTINAL
__ Bowel Problems
__ Constipation
__ Diarrhea
__ Hemorrhoids
__ Gallbladder Problem
__ Nausea/ Vomiting
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Liver Problems
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Tuberculosis
__ Shortness of Breath
__ Emphysema
__ COPD
__ Cold/Flu
__ Cough/Wheezing

__ Covid 19 / Date:

Have your received your Covid 19

Vaccine? Y/N Date:_____

GENITOURINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Disease
__ Painful Urination
__ Kidney Stone
__ Loss of Bladder Control
__ STD

NEUROLOGIC
__ Stroke
__ Seizures
__ Head Injury
__ Brain Aneurysm
__ Numbness
__ Severe Headaches
__ Pinched Nerves
__ Parkinsons
__ Stiff Joints
__ Carpal Tunnel
__ Spinning/Balance
__ Multiple Sclerosis
__ Migraines

ALLERGIC/IMMUNOLOGIC
__ Hives
__ Immune Disorder
__ HIV/AIDS
__ Allergy Shots
__ Cortisone Use

INTEGUMENTARY
__ Skin Ulcers
__ Skin Disease
__ Eczema
__ Psoriasis
__ Rashes
__ Dryness
__ Sensitive Skin
__ Boils

HEMATOLOGIC/LYMPHATIC
__ Hepatitis
__ Blood Clots
__ Cancer
__ Easy Bruising
__ Easy Bleeding
__ Fevers/Chills/Sweats

PSYCHIATRIC
__ Depression
__ Anxiety Disorder
__ Unusual Stress
__ ADHD
__ Mental Disorder
__ Alcoholism
__ Drug Addiction

ENDOCRINE
__ Diabetes Type I or II
__Thyroid – Hyper or Hypo
__ Hair Loss
__ Excessive Thirst

WOMEN ONLY
__ Difficult Periods
__Hot Flashes
__ Irregular Cycles
__ Breast Pain
__ Lump In Breast
__ Difficulty Becoming Pregnant
__ Pregnancy Complications
__ Pain With Intercourse
__ Pelvic Pain
__ Cramps
__ Birth Control
__ Pregnant At This Time
__ Date Of Last Period Ended
__ Last Gynecologic Exam

MEN ONLY
__ Testicular Pain
__Prostate Problems
__ Difficult Erection
__ Low Sperm Count
__ Pain With Intercourse
__ Pelvic Pain

Have you had any recent: surgeries, trauma, Illness, recent diagnosis or new medications in the past year?

If yes, please explain _____

_____

Name:_____ Date:_____

BP:_____/_____ HR:_____

Height:_____ Weight:_____

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