Chiropractic • Medical • Physical Therapy • Massage Therapy • Nutrition

Account #: ________ **MT Initials:** ________

Massage Therapy—Confidential Case History

Name ______________________ Date of Birth ____________ Age ______

Address ______________________ City __________ State _____ Zip ______

Phone cell ( ) __________ home ( ) __________ email ______________

Occupation ____________ Work (___) ___-____ Sex ____M ____F **(ARE YOU PREGNANT? YES NO)**

Preferred method of contact for appointment reminders (please circle one) *phone call (home or cell) / text / email*

Reason for seeking a massage? Stress reduction___ Experience___ Relaxation___ Other __________

How did you first hear about us? ______________ Have you had a professional massage before? YES NO

Is this your first visit to our office? YES NO Have you utilized any of our other services? YES NO

Briefly explain your current problem ______________________

When did you first notice it? ______________________

Does your problem interfere with your ___Job? ___Sleep? ___Daily routine?

What activities aggravate the condition? ______________________

What helps the condition? ______________________

Is it getting ___Worse? ___Better? Is it ___constant? ___ comes and goes?

Do you have alcohol or drugs in your system or are you taking any Rx medication? ______________

Previous injuries or surgery? ______________________

Please check **ALL THAT CURRENTLY APPLY**:

___Neck Pain/Stiffness	___Headache	___Dizziness	___High/Low Blood Pressure	___Advanced Osteoporosis
___Low Back Pain/Stiffness	___Muscle Tightness	___Nervousness	___Heart Problems	___Degenerative/Rheumatoid Arthritis
___Shoulder/Arm Pain	___Jaw Problems	___Insomnia	___Artery/Vein Problems	___High Fever / Infection
___Hip/Leg Pain	___Hearing Problems	___Fatigue	___Shortness of Breath	___Diabetes (I or II)
___Numbness/Tingling	___Sinus Problems	___Depression/Anxiety	___Skin allergies	___Cancer
___Trauma/Injury/ Whiplash	___Wear Contacts?	___Thyroid Problems	___Open sores / Rash	___Stroke

Some of your symptoms listed above may be originating from abnormal spinal structure and function. Check **YES** to have a consultation with one of our *Board Certified Chiropractic Physicians*

____**Yes**, I would like the complimentary consultation following my massage. ____**No**, I waive my right to have a consultation.

I hereby consent to bodywork with the understanding that massage therapy is given for the purpose of stress reduction, relief from muscular tension, or for increasing circulation and energy flow. ****For Detoxification Massage only: due to the strength of essential oils, there may be some irritation to those with sensitive skin.** I understand that the results of massage vary from individual to individual and that no specific results can be guaranteed. I understand that a massage therapist does not treat, prescribe for, or diagnose any illness, disease or any other physical or mental disorder, injury or condition. Nothing said or done by the massage therapist should be construed as such. I understand that a massage therapist must be aware of my physical conditions and have stated all my known medical conditions and will keep the massage therapist updated on my physical health. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the "full" scheduled appointment. **Cancellation Policy**: You will be charged for cancellations of less than 24 hours notice. We hope you understand this policy and respect the value of our time. Thank you.

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Signature (Guardian Signature if under 18 years of age) Relationship Date