NATURAL HEALTH CHIROPRACTIC MASSAGE INFORMATION

Name: _____ Occupation: _____
Date of Birth: _____ Email: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ (carrier: _____) Home phone: _____
Preferred Method of contact: cell email home phone
Emergency Contact: _____ Phone: _____
How did you hear about us? _____

Medical History

Please check any of the following medical conditions/symptoms that you have had in the last year.
All information will be kept confidential.

__ Heart Disease __ Epilepsy/seizures __ Lupus __ Stress
__ Spinal Problems __ Tendonitis/Bursitis __ Jaw Pain __ Arthritis/Gout
__ Tense Muscles __ Diabetes __ Bone/Joint Disease __ Varicose veins
__ Osteoporosis __ Back pain __ Blood clots __ Fibromyalgia
__ Cancer __ Chronic fatigue __ Cardiac/circulatory issues
__ Chronic pain: _____ __ Contagious diseases: _____
__ High Blood Pressure (taking medicine? Yes/No) __ Low Blood Pressure (taking medicine? Yes/No)
__ High Cholesterol (taking medicine? Yes/No) __ Pregnant: #weeks _____
__ Headaches (how often?) _____ __ Allergies: _____
__ Tension/soreness in a certain area?: _____ __ Numbness/stabbing pains: _____
__ Are you very sensitive to touch or pressure in any area? _____
__ Recent Injury/Surgery/Accidents: _____
__ Any other medical conditions or medications I should know about: _____
__ Additional conditions: _____

Treatment Goals

By checking, I do **NOT** give consent to massage the following areas.

__ Pectorals __Glutes __Feet __Arms __Head __Neck __ Face __ Back

Areas to Avoid: _____ I tend to bruise easily: ___ YES ___ NO
I would like to keep the massage pressure around 1 2 3 4 5 6 7 8 9 10 (1 being extremely light and 10 being very deep) My massage/bodywork goals are: _____

I know and understand the following: 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that failure to do so may lead to delayed soreness and bruising.** Massages take place in a therapeutic hour which is 5-10 min less than a full hour. 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 of which I am aware. 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. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand 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 of the scheduled appointment. **I agree to give at least 4 hours notice for all cancellations, and am aware that I may be charged for missed appointments where advanced notice is not given.**

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____