phillipsfamily CHIROPRACTIC

Confidential Client Information

Thank you for choosing our practice for your Massage Therapy needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name ______________________________ Date ____________
First Middle Initial Last

Address ____________________ City ____________ State ______ Zip ______

Sex: ☐ Female ☐ Male Birth date ____________ E-mail ____________________

Home Phone (____) ____________ Cell Phone (____) ____________ Work Phone (____) ________

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Client Employer / School ____________________ Occupation ____________________

Whom may we thank for referring you to us? ______________________________

Person to contact in case of emergency ____________________ Phone (___) ____________

Accident Information

Is your condition due to an accident? ☐ Yes ☐ No Date ____________ ☐ Auto ☐ Work ☐ Other

Massage History

Have you ever received a professional massage? ☐ Yes ☐ No

Why did you come for our service? ☐ Relaxation ☐ Pain ☐ Therapy ☐ Other ____________

What results would you like to achieve? ______________________________

Prioritize the areas of your body that you wish to be massaged. Please note any areas that you **prefer not to be** massaged. ______________________________

Client Condition – If you checked Pain or Therapy above.

When did your symptoms appear? __________ Is the pain constant or does it come and go? (Circle One)

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Other treatments for this condition: ☐ Medication ☐ Chiropractic ☐ Physical Therapy ☐ Surgery

Health History

☐ AIDS/ HIV	☐ Diabetes	☐ Joint Replacement	☐ Parkinson's disease	☐ TMJ
☐ Anemia	☐ Epilepsy	☐ Migraines	☐ Polio	☐ Vertigo
☐ Arthritis	☐ Fibromyalgia	☐ Mononucleosis	☐ Psoriasis	☐ Other
☐ Asthma	☐ Heart Disease	☐ Multiple Sclerosis	☐ Rheumatoid Arthritis	____________
☐ Breast Cancer	☐ Hepatitis	☐ Osteopenia	☐ Spinal Fractures	____________
☐ Cancer	☐ Herniated Disc	☐ Osteoporosis	☐ Stroke	____________

Exercise ☐ None ☐ Daily ☐ Moderate ☐ Heavy **Work Activity** ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor

Lifestyle ☐ Smoking ☐ Coffee/ Caffeine ☐ Alcohol ☐ High Stress Level

Medications ____________________ **Vitamins/Supplements** ____________________

Female Specific Are you currently **pregnant**? Yes ☐ No ☐ Due Date ____________________

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my health care provider if I ever have a change in health.

I understand that massage therapy is for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy is in no way a substitute for examination, diagnosis or treatment by a physician. I understand that massage therapists are not qualified to diagnose, prescribe or treat any illness and are not qualified to perform spinal adjustments.

______________________________ ____________

Signature of Client, Parent, Guardian or Personal Representative Date