***River Parkway Chiropractic - Massage Client Health History Intake***

Please take a moment to answer the following questions. The information you provide will be used to customize your session to your needs, and exclude any techniques that may be medically unsuitable for you.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male [ ]  Female [ ]

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:(H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Chiropractor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact & Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications/OTC/Supplements & WHY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer the following to the best of your knowledge.**

1. Have you had a professional massage before? [ ] Yes [ ] No

2. Do you have allergic reactions to oils, lotions, or other substances put on your skin, or to any nuts? [ ] Yes [ ] No

3. Do you have any particular goals for this massage session? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. If you are currently under medical supervision please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Please check any condition/symptom listed below that applies to you:

**Musculoskeletal System Nervous System Circulatory System Digestive System**

[ ]  Artificial Joint [ ]  Alzheimer’s [ ]  Atherosclerosis [ ]  Crohns

[ ]  Baker’s Cyst [ ]  Herpes Zoster/Shingles [ ]  Deep Vein Thrombosis (DVT) [ ]  IBS

[ ]  Bursitis [ ]  Multiple Sclerosis [ ]  Heart Attack [ ]  Ulcers

[ ]  Fibromyalgia or CFS [ ]  Parkinson’s Disease [ ]  High Blood Pressure [ ]  Ulcerative Colitis

[ ]  Muscular Dystrophy [ ]  Peripheral Neuropathy [ ]  Leukemia [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Osteoarthritis [ ]  Seizures [ ]  Low Blood Pressure

[ ]  Osteoporosis [ ]  Spinal Cord Injury [ ]  Stroke

[ ]  Plantar Fascitis [ ]  Numbness [ ]  Varicose Veins

[ ]  Rheumatoid Arthritis [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Tendonitis

[ ]  Whiplash

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lymph/Immune System Respiratory System Integumentary System (Skin) Miscellaneous Conditions**

[ ]  Allergic Reactions [ ]  Asthma [ ]  Athlete’s Foot [ ]  Cancer

[ ]  Chronic Fatigue [ ]  Chronic Bronchitis [ ]  Boils [ ]  Depression

[ ]  HIV/AIDS [ ]  Sinusitis [ ]  Burns [ ]  Diabetes

[ ]  Lupus [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Cold Sore/Herpes [ ]  Easy Bruising

[ ]  Lymphoma [ ] Dermatitis [ ]  Headaches

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Impetigo [ ]  Migraines

 [ ] Open Sores/Wounds [ ]  Numbness

[ ]  Psoriasis [ ]  Pregnant

[ ]  Rashes [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Warts

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Please list any accidents or operations you have had and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Please list any Sports/Regular Physical Activities **you do: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

8. Please circle the level of physical activity you do: None Light Moderate Heavy

9. Please mark on the body forms with an **“X”** where you are experiencing any tension, stiffness or other discomfort. Please describe the sensation (burning, stinging, aching, pins-n-needles, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



\_\_\_\_\_\_\_ (initials) I understand the massage therapy given here is for general wellness purposes, including stress reduction, relief from muscular tension or spasm, the promotion of circulation, lymph activity, and flexibility. I understand a massage therapist will never touch genitals, breast tissue, or any other areas I instruct them not to touch. I understand massage therapists do not diagnose illness, disease, or any other physical or mental disorder, do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I also understand that it is my responsibility to inform the massage therapist of any existing medical conditions I may have, and keep the massage therapist informed of any changes in my health and medications in the future. I understand that potential risks of massage include: mild, short term muscle soreness due to movement of irritating metabolic wastes; mild surface level bruising. I understand I have the right to refuse massage therapy treatment at any time during the session. Consent for Treatment: I authorize the performance of massage therapy techniques and procedures and understand that I will receive them from a certified massage therapist.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_