ALIGN Chiropractic
SPINE & SPORTS REHAB

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MASSAGE CLIENT HEALTH HISTORY FORM

Name:_____ DOB:_____ Age:_____
Last First MI

Home #: _____ Cell #:_____ E-mail:_____

Address: _____ City: _____ Zip:_____

Occupation: _____ Employer:_____ Work #:_____

Patient Primary Dr.:_____ Name of Practice:_____

Primary Dr. Office Phone #:_____ Date of last physical exam: _____

Emergency Contact Person:_____ Phone #:_____

Have you ever received professional massage/bodywork before? □ No □ Yes
If yes, how recent:_____

For your massage, what type of pressure do you prefer: □ Light □ Medium □ Deep

Do you have a preference to amount of noise (talking, music, etc.) during your massage:
□ Silence □ Music only □ Music and some talk □ Other:_____

What are your goals/expected outcomes for receiving massage/bodywork?:_____

_____

How do you feel today?_____

List and prioritize any current symptoms/issues for which you are seeking massage/bodywork (stress, pain, stiffness, numbness/ tingling, swelling, etc.):_____

_____

Do these symptoms interfere with your activities of daily living (sleep, exercise, work, etc.)? □ No □ Yes
If yes, please explain:_____

Please list any medications that you currently are taking:

Medication:	Reason for Usage:
_____	_____
_____	_____
_____	_____
_____	_____

Please list any nutritional supplements you currently take below:

Supplement:	Reason for Usage:
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently under the care of a physician, chiropractor, or other health care professional for any reason? □ No □ Yes
If yes, please list reason:_____

Are you wearing contacts?: □ No □ Yes
Are you wearing dentures?: □ No □ Yes
Are you wearing a hairpiece?: □ No □ Yes
If female, are you currently pregnant?: □ No □ Yes

Do you have a history of any major injuries or surgeries?:_____

_____

Please indicate if you currently have any of the following health conditions, by circling:
Blood Clots , Infection , Congestive Heart Failure , Contagious diseases , Pitted Edema

Please indicate conditions that you currently have or have had in the past, by circling:

Muscle/Joint Pain : Current / Past	Muscle/Joint Stiffness: Current / Past	Numbness/Tingling: Current / Past
Swelling: Current / Past	Bruise Easily: Current / Past	Sensitive to Touch/Pressure: Current / Past
High/Low Blood Pressure: Current / Past	Stroke, Heart Attack: Current / Past	Varicose Veins: Current / Past
Shortness of Breath/Asthma: Current / Past	Cancer: Current / Past	Parkinson's/MS/CP: Current / Past
Epilepsy/Seizure: Current / Past	Headaches/Migraines: Current / Past	Dizziness: Current / Past
Digestive (Crohn's, UC): Current / Past	Bloating/Constipation: Current / Past	Kidney disease/infection: Current / Past
Arthritis: Current / Past	Osteoporosis: Current / Past	Scoliosis: Current / Past
Broken Bones: Current / Past	Allergies: Current / Past	Diabetes: Current / Past
Thyroid condition: Current / Past	Depression/Anxiety: Current / Past	Memory Loss/Confusion: Current / Past

Is there anything else that you would like our massage therapist to know?/Comments:_____

_____

_____

CONSENT FOR TREATMENT

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 further understand that massage/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 medical 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 treatment 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. Understanding all of this, I give my consent to receive care.

Client Signature:_____ **Date:**_____

Parent/Guardian Signature (in case of minor):_____ **Date:**_____