Fredericton Family Chiropractic:
A Creating Wellness
Centre

Name: _____ Date of Birth (Age): _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Work: _____

E-mail: _____ Referred by: _____

Emergency Contact: _____ Phone: _____

Occupation: _____

Describe your general diet and exercise habits: _____

_____

Describe how well you sleep: _____

Describe your general health: _____

Have you ever had a massage before? _____ How long ago? _____

Have you ever been involved in an injury or accident? _____ When? _____

What kind of care did you receive? _____

Do you feel that you have recovered from these events? _____

Do you have any chronic, ongoing conditions that you deal with on a regular basis?

Explain. _____

Current Medications: _____ Condition it treats: _____

_____ _____

_____ _____

Do you have any internal pins, wires, artificial joints, or special equipment? If so, what and where: _____

_____

Why are you here? What do you hope to accomplish? _____

_____

If suffering from pain, what causes it and what activities make it worse? _____

_____

What would you like to be different? _____

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INSTRUCTIONS: ***Please check any of the following conditions or symptoms that you currently have or have had in the past.***		
❑ Allergies:_____ _____	❑ IRRITABLE BOWEL SYNDROME	❑ DEPRESSION
❑ HEART SURGERY/ PACEMAKER	❑ DIGESTIVE PROBLEMS	❑ MULTIPLE SCLEROSIS
❑ HEART DISEASE	❑ CROHN DISEASE	❑ HEADACHES
❑ VARICOSE VEINS	❑ GALLSTONES	❑ STROKE
❑ CLOTTING DISORDERS	❑ HEPATITIS	❑ REDUCED SENSATION
❑ CARDIAC OR CIRCULATORY PROBLEMS	❑ DIABETES	❑ SLEEP DISORDERS
❑ HIGH / LOW BLOOD PRESSURE	❑ HYPOTHYROIDISM/ **HYPER**THYROIDISM	❑ EPILEPSY OR SEIZURES
❑ DEEP VEIN THROMBOSIS	❑ KIDNEY PROBLEMS	❑ TUBERCULOSIS
❑ THROMBOPHLEPITIS	❑ ULCERS/COLITIS	❑ DIFFICULTY BREATHING
❑ OSTEOPOROSIS	❑ CANCER	❑ ASTHMA
❑ ARTHRITIS	❑ EDEMA	❑ EMPHYSEMA
❑ FIBROMYALGIA	❑ LEUKEMIA / LYMPHOMA	❑ SINUS PROBLEMS
❑ CARPAL TUNNEL SYNDROME	❑ HIV / AIDS	❑ SKIN CONDITIONS
❑ TMJ DYSFUNCTION	❑ LUPUS	❑ WARTS
❑ THORACIC OUTLET SYNDROME	❑ STRAINS, SPRAINS, TENDINITIS	❑ PREGNANT? DUE: _____

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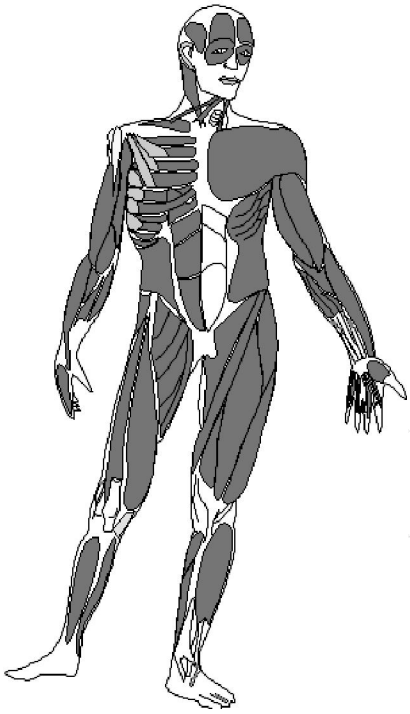
Please indicate **by circling** where you have pain:



1. I am aware that draping will be used during the massage session.____

2. I understand that my feedback is an essential element in my treatment, therefore if at any time I should become uncomfortable during the massage, I may bring it to my therapist's attention and request that the session end. ____

3. If I am unable to keep an appointment, I understand that an 8hr. notice is required, otherwise, I will be charged for the time reserved. ____

I have read and I fully understand this form in its entirety. If at any time there are changes in the information given or in my condition, I will notify my therapist, and update this form before receiving additional massages.

The Massage Treatment given here is for the sole purpose of stress reduction, relief from muscle tension of spasm and to increase circulation and energy flow.

The Massage Therapist does not diagnose or prescribe for medical illness, disease, or any other physical or mental disorder.

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The Massage Therapist does not perform spinal manipulations (this is the job of our chiropractors). Massage Therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for any ailment that you have.

It is the Client's (your) responsibility to explain and discuss all physical conditions with the Massage Therapist so that they may do their job. Your Massage Therapist is an independent professional and is solely responsible for your treatment.

_____ _____

Client Signature Massage Therapist Signature