DENN CHIROPRACTIC
Healing the Body From Within

MASSAGE HEALTH HISTORY FORM

PATIENT INFORMATION

Name: _____ Date: _____ / _____ / _____

Occupation: _____

Emergency Contact: _____ Emergency Contact Phone: _____ / _____ / _____

==========

MEDICAL HISTORY

(Please Check all the Apply)

___ Osteoarthritis ____ Tendonitis ____ Neck/Back problems ___ Joint disorders ___TMJ/jaw disorders

___ Osteoporosis ____ Heart Attack ____ Rheumatoid Arthritis ___ Seizures ___ Deep Vein Thrombosis

___ Blood Clots ____ Recent Fever ____ Recent Fractures ___ Diabetes ___ Numbness / Parasthesia

___ High/Low BP ____ Epilepsy ____ Sprain/Strains ___Open Sores ___ Swollen Glands

___ Asthma ____Headaches ____ Migraines ___ Surgeries ___ Kidney Disease

___ Artificial Joints ____ Strokes ____ Cancer ___ Varicose Veins ___ Golfer's/ Tennis Elbow

___ Phlebitis ____ Fibromyalgia ____ Carpel Tunnel Syn. ___ Heart Conditions ___ Circulatory Disorders

___Allergies/ Hypersensitivities ____Contagious Skin Conditions ____Arteriosclerosis / Atherosclerosis

==========

The following information will be used to help your Therapist plan a safe and effective massage session.

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

Have you ever had a professional massage before? ___Yes ___ No If yes, how often? _____

Do you have any difficulty with lying on your front, back or side? ___ Yes ___ No

If Yes, Please explain: _____

Do you have any allergies to Oils, Lotions, Ointments, Fruit, Nuts? ___ Yes ___ No

If Yes, Please explain: _____

Do you have sensitive skin? ___ Yes ___ No

Are you wearing: ___Contacts ___Dentures ___Hearing Aids ___Prothesis ___Hair pieces / Extensions

Do you have a job that you sit for long hours a day? ___ Yes ___ No

If Yes, Please explain: _____

Please list any Medications you are currently taking: _____

Have you had any injuries or surgeries in the past or recently that may influence today's session / treatment? ___Yes ___No

If Yes, please explain:_____

What type of Massage do you prefer? ___Deep Tissue ___ Relaxation ___ Hot Stone ___ Other:_____

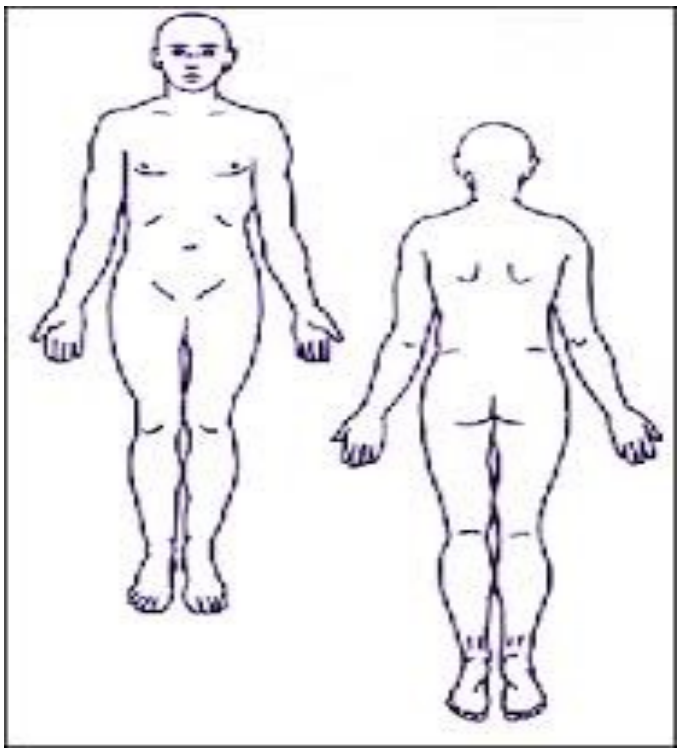
What type of Pressure do you prefer? ___Light ___ Medium ___ Firm

Do you any specific Goals / Expectations for receiving this massage: ___ Yes ___ No

If Yes, Please explain:_____

==========

Please Circle all the areas of complaint for this session



Are you currently under any medical supervision?

___Yes ___No If Yes, Explain:_____

Do you currently see a Chiropractor? ___Yes ___No

Is there anything else about your health history that you think would be useful for your massage therapist to know to pan a safe and effective massage session for you?_____

_____

What is / are the MAIN areas that you are coming in for

This session:_____

==========

CONSENT FOR TREATMENT

I understand that the massage I receive is provided for the basic purpose of relaxation and relief if muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes of massage may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician or other qualified medical specialist for any medical of physical ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illnesses, and that nothing is said in the course of the session given should be construed as such. Because massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part shall I fail to do so.

Signature of Client: _____ Date: ____ / _____ / _____

Signature of Massage Therapist: _____ Date: ____ / _____ / _____