Wilcox Chiropractic & Massage Therapy

Health History Form

Personal Information

Name: _____ DOB: _____ Age: ____ Gender: _____

Phone C: _____ H: _____ E-MAIL: _____

Address: _____ City/State/Zip: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

How did you hear about us? _____

Primary Care Doctor: _____ Phone: _____

Health Information **(please answer YES or NO)**

Are you taking any medications? _____ If yes, please list: _____

Any allergies or hypersensitivities? _____ If yes, please list: _____

Are you pregnant? _____ If yes, how many months? _____ Due Date: _____ High risk factors? _____

History of joint replacement surgery? _____ If yes, which joints and when? _____

Any implants? _____ If yes, what and where? _____

Areas of broken skin (e.g. rash, wounds)? _____ If yes, where? _____

List any type of surgeries you have had and the dates they occurred? _____

_____

Please describe any other health conditions, recent injuries, or sprains/strains: _____

_____

Are you currently under medical supervision or receiving other medical interventions? _____ If yes, please explain ____

_____

Health Conditions

Health Condition	Past/Present	Health Condition	Past/Present
Anxiety/Stress		Fibromyalgia	
Ankylosing Spondylitis		Gout	
Arthritis		Headaches/Migraines	
Bleeding Disorder		Hearing loss	
Blood Clot		Heart Attack	
Bruise easily		High Blood Pressure	

Bursitis		Kidney Disease	
Cancer/Tumor		Low Blood Pressure	
Depression		Multiple Sclerosis	
Diabetes		Muscle weakness	
Neuropathy (numbness)		Seizures	
Osteoporosis		Strains/Sprains	
Osteoarthritis		Stroke	
Reactive Arthritis		Varicose Veins	
Rheumatoid Arthritis		TMJ Disorder	
Sciatica		Vertigo/Dizziness	

Please explain any conditions you have marked above: _____

_____

_____

Any areas of swelling? _____ If yes, where? _____

Any current infectious or contagious conditions? (e.g. HIV, TB, fungal infections, shingles, warts, etc.) _____ If yes, please list _____

Massage Information

Have you had a professional massage before? _____ If yes, how recently? _____

What type of massage technique would you like (e.g. Prenatal, Deep Tissue, Relaxation, Hot Stone, Therapeutic, Reflexology)? _____

What type of pressure do you prefer (e.g. light, medium, deep)? _____

Please describe the specific reason for your massage today. _____

_____

Are there any areas you do NOT want to be massaged (yes or no)? _____ If yes, where? _____

What are your goals for today's session? _____

_____

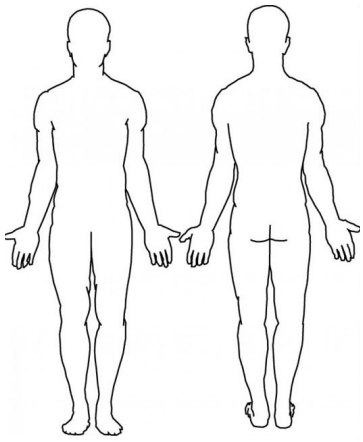
Please indicate any areas of pain or discomfort on the image below and describe:

_____

_____

_____

_____



By signing below, I acknowledge that I have completed this form to the best of my ability and agree to inform my therapist if any of the above information changes at any time.

Client Signature: _____ Date: _____

Client Print Name: _____