Schroeder Chiropractic - Massage Therapy - Client Health History Intake

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

Name_____ Gender (M) (F) D.O.B. _____

Address_____City_____State_____Zip Code_____

Email Address_____ Phone (H)_____(W)_____

Occupation_____Referred by_____

Emergency Contact_____Phone_____

Physician_____Chiropractor_____

Sport/Physical Activities_____

Current Medications/Supplements_____

Please answer the following to the best of your knowledge

1. Have you had a professional massage before? **Y N**
2. Do you have allergic reactions or sensitivities to oils, lotions, or other substances put on your skin? **Y N**
3. Is there a particular area of your body in which you are experiencing tension, stiffness, or other discomfort? **Y N**
4. If yes, please describe_____
5. Do you have any particular issues for this massage session?_____
6. If you are currently under medical supervision, please explain_____
7. Accidents/Surgeries and dates_____
8. Please check any conditions/symptoms listed below that applies to you

_Allergies
_Atherosclerosis
_Athlete's Foot/Fungal Infection
_Artificial Joint
_Cancer/Tumors
_Circulatory Disorder
_Cold Sores/Herpes
_Contact Lenses
_Decreased Sensation
_Dentures
_Diabetes Type I, Type II
_Difficulty lying on Back, Front, Side
_Digestive Problems
_Easy Bruising
_Epilepsy
_Fibromyalgia or CFS
_Fractures
_Headaches
_Heart Condition
_High or Low Blood Pressure
_HIV or AIDS
_Joint Disorder
_Lice or Scabies
_Lung or Breathing Problems
_Open Sores/Wounds
_Hearing Aid
_Osteoporosis
_Phlebitis
_Pregnancy-how far along?
_Psoriasis
_Rosa Eczema
_Recent Accident or Injury
_Recent Surgeries
_Rheumatoid/Osteoarthritis
_Scleroderma
_Spinal Problem
_Stroke
_Swollen Glands
_Ulcers
_Varicose Veins

9. Anything else about your health history your massage therapist should know before planning your session?_____

_____

_____(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 the massage therapist will never touch genitals. breast tissue or any other areas I instruct them not to touch. I understand massage therapist does not diagnose illness, disease, or any other physical or mental disorders. Also we do not prescribe medical treatment or pharmaceuticals or 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 condition 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 includes mild, short-term muscle soreness due to movement, irritation of metabolic wastes and mild surface level bruising. I understand I have the right to refuse massage therapy treatment at any time during the session.

Patient's signature_____ Date_____