Massage Therapy – New Patient Information

Name: _____ Date: _____

Address: _____ Postal Code: _____

Phone Numbers (H): _____ (O): _____ (Cell): _____

Date of Birth: _____ (YYYY/MM/DD) Occupation: _____

Email: _____ Emergency Contact: _____ Ph: _____

Activities: _____

Medications: _____

Medical Doctor: _____ Chiropractor: _____

How did you hear about our clinic: (please check one):

○ Google ○ Sign ○ Location ○ Other_____ Referral Name: _____

Do you have a specific complaint? _____

_____

Do you know what caused this problem? _____

_____

When do you experience the pain? (i.e. Sleep? Morning? After Activity?) _____

_____

_____

How long does it last? _____

Describe the pain? (sharp, dull, numbness, tingling, aching, stabbing, etc.) _____

_____

_____

What relieves the pain? _____

Have you had any other injuries or surgery? If so, please describe and give date(s): _____

_____

_____

Have you seen any other health care provider for this complaint? _____

_____

How is this affecting your day-to-day living? _____

_____

Are you pregnant or have you had a pregnancy since your last visit? _____

_____

Have you seen another chiropractor since your last visit? NO □ YES □

If yes, (Approximately how many visits?) _____

History of cancer recently or in the past five years? NO □ YES □

If yes, Describe: _____

Are you H.I.V. +? NO □ YES □

PLEASE CHECK OFF ANY OF THE FOLLOWING THAT APPLY TO YOU:

- ☐ Rheumatoid Arthritis
- ☐ Fatigue
- ☐ Abdominal Pain
- ☐ Swelling of Joint
- ☐ Diabetes
- ☐ Fractured Vertebrae
- ☐ Spine tender-to-touch
- ☐ Respiratory/Urinary
- ☐ Bone Pain
- ☐ Low Back Pain
- ☐ Varicose Veins
- ☐ Osteoporosis
- ☐ Brain Tumors
- ☐ Asthma
- ☐ Heart Attack
- ☐ Stroke
- ☐ Skin Condition
- ☐ Morning Stiffness
- ☐ Crunching/Grinding
- ☐ Multiple Joint Pain
- ☐ Numbness/Tingling
- ☐ Dizziness
- ☐ Headaches
- ☐ Fainting
- ☐ Pins, Plates, or Prosthesis
- ☐ Weakness of Arm/Leg/Hand/Foot

Please indicate any conditions not mentioned above: _____

_____

I declare the information on this form to be true and correct in all respects. While rare, some patients may experience short-term aggravation of symptoms, muscle, and ligament sprains or strains, bruising or rib fractures as a result of massage therapy.

I acknowledge I have discussed, or have had the opportunity to discuss, with my massage therapist the nature and purpose of massage therapy in general and my treatment as well as the contents of this consent.

I consent to the massage therapy treatment offered or recommended to me by my massage therapist. I intend this consent to all my present and future massages.

Client Name (please print): _____

Client Signature: _____ Date: _____