Elite Chiropractic New Client Form Massage Therapy

Name:_____ Date:_____
(Last) (First) (M.I)

Address: _____
(House/Apt#) (Street) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____

Date of Birth:_____ Employer/Occupation: _____

Work Phone:_____ Email:_____

Physician: _____
(Name) (Name of Clinic) (Phone)

#1 Emergency Contact:_____
(Name) (Phone) (Relationship)

How did you hear about Elite Massage?:_____

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

Reason for Visit?_____

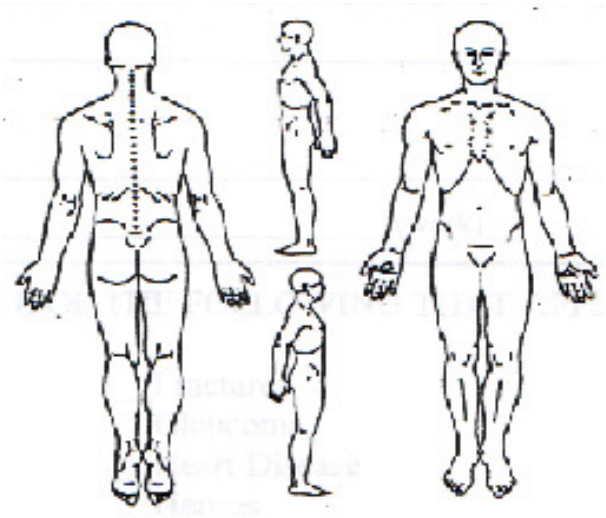
Do you prefer a firm, deep tissue massage, or a light pressure massage?_____
_____

Please mark appropriate problem areas:

⊗ Inflammation

≈ Spasm * Bruise

• Tender Point ○ Pain



Are you currently taking any medication? Yes No
If yes, please list the medications: _____
_____
_____

Please list all vitamins/supplements you are currently taking_____
_____
_____

Have you recently had any major surgeries? Yes No
Date of surgery: _____

Is your condition work or auto crash related? Yes No
If yes, please describe: _____
_____
_____

Date of injury:_____

Are you currently making visits to a physician, chiropractor, or physical therapist for an ongoing problem? Yes No

If yes, please describe: _____
_____
_____

A checklist of information and various conditions that may help the therapist screen for contraindications or use adaptive measures during treatment. Please check all that apply.

Acid Reflux
Alcohol use: _____
Allergies
Arthritis
Autoimmune disorder (HIV/AIDS)
Bladder infection
Breathing problems
Bruise easily
Bursitis
Cancer: _____
Carpal tunnel syndrome
Cerebral Palsy
Chronic Fatigue Syndrome
Chronic Pain
Colitis
Constipation
Contact lenses

Crohn's Disease
Diabetes
Diarrhea
Diverticulitis
Dizziness
Osteoporosis
Epilepsy
Fainting
Fatigue
Fibromyalgia
Foot problems (including bunions, corns, plantar warts, calluses,
Problems walking
Headaches or migraines
Hearing impaired
Heart condition
Herpes/shingles
High blood pressure
Indigestion
Infectious disease (please list)_____
Intestinal gas/bloating
Irritable bowel syndrome
Low back pain
Low blood pressure
Lymphedema
Mid Back Pain
Multiple Sclerosis
Neck Pain
Nervous stomach
Neurological disorders
Vertebral disc problems
Paralysis
Parkinson's disease
Plantar Fasciitis
Phlebitis
Pregnant
Rashes
Sciatica
Scoliosis
Sensitivity to cold, heat, or pressure
Sinus Congestion
Sleep disorders
Skin conditions
Sore Muscles
Spasms/Cramps
(TMJ) disorder
Tendonitis
Thoracic outlet syndrome
Varicose veins
Ulcers
UTI

Other congenital or acquired disabilities (please list):_____

Informed Consent

The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. I agree to inform the therapist of any experience of pain during the session. I understand this does not deter me from seeking medical treatment for medical conditions. I understand that no inappropriate comments or conduct will be tolerated. Any indication of such behavior will automatically end the session.

I agree to update the massage therapist in regards to changes in my health and understand that there shall be no liability on the therapists part should I forget to do so. I agree to hold harmless the establishment, all management, including volunteers, from and against any and all claims. I agree to handle suit at its sole expense and agree to bear all costs related even if claims, etc. are groundless, false and fraudulent.

_____ _____

Signature Date

_____ _____

Guardian's Signature (If under 18) Date