Let our *family* care for yours
BROWN FAMILY CHIROPRACTIC

MASSAGE HEALTH HISTORY FORM

Name: _____ Date:_____
Address: _____
City, State, Zip: _____
Primary Phone Number: _____Secondary Phone Number: _____
DOB: _____ Age: _____ Sex: _____
Occupation: _____
Email: _____@_____
Emergency Contact: _____ Relationship: _____
Phone Number: _____
Primary Health Care Provider: _____
Phone Number: _____

What brings you to this office today? _____
Have you ever had a massage before? ⇫ Yes ⇫ No If yes, most recent: _____
Where in your body do you feel stress or tension? _____
Using the pain scale below, how would you rate your discomfort (*please circle one)*?

Today: (*no pain*) 0 1 2 3 4 5 6 7 8 9 10 (*worst pain imaginable)*

Typical day: (*no pain*) 0 1 2 3 4 5 6 7 8 9 10 (*worst pain imaginable)*

What do you do for relaxation? _____
Any ongoing chronic conditions? _____
Hospitalizations/Surgeries (*including cosmetic*)? _____
_____
Are you currently under the care of a Physician or Healthcare Provider? _____
Medications or supplements you are currently taking: _____
_____
_____
Is there anywhere that you would *NOT* like to be touched today? _____

Are you allergic to any lotions? _____ Do you wear glasses? _____
Do you wear prosthetics? _____

Please *CIRCLE* and let me know if you have experienced (past or currently) any of the following:

Integumentary:
Boils/Cysts
Fungal Infections
Herpes simplex
Warts
Eczema
Psoriasis
Skin Cancer
Allergies: _____

Lymph and Immune
Edema
Hodgkin's Disease
AIDS/HIV
Chronic Fatigue Syndrome
Lupus

Circulatory
Anemia
Thrombophlebitis
Heart Disease
High/Low Blood Pressure
Varicose Veins
Diabetes
Clotting Disorders
PAD
Restless Leg Syndrome

Urinary
Kidney Stones

Nervous
Multiple Sclerosis
Peripheral neuropathy
Headache or Migraines
Stroke
Seizure Disorders
Reduced Sensations

Respiratory
Asthma
Emphysema
Sinusitis
Tuberculosis
Smoker

Digestive
Cirrhosis
Ulcerative colitis
Diverticulosis
Gallstones
Hepatitis
Irritable Bowel Syndrome/Crohn's

Musculoskeletal
Fibromyalgia
Rheumatoid Arthritis
Osteoarthritis
TMJ Dysfunction
Strains, sprains, tendonitis
Carpal Tunnel Syndrome
Thoracic Outlet Syndrome
Cramping, spasms, soreness
Limited range of motion

Reproductive
Breast/Prostate Cancer
Endometriosis
Ovarian cysts
Painful Menstruation
Are you pregnant? ⇫ Yes ⇫ No
How far along?_____

I understand that massage therapy is not a substitute for medical examination or diagnosis, and that I should see a Health Care Provider to address concerns that are outside the scope of a massage therapist's practice. I am aware that massage is contraindicated for some medical conditions and that I affirm that I have answered all questions truthfully to the best of my knowledge, and agree to update the therapist on any changes in my health status and medical history. I agree to inform the therapist of any pain experienced during the initial and subsequent sessions, and furthermore understand that I have the right to refuse any treatment or ask that it be modified in regard to pressure or modality.

Client Signature: _____ Date:_____
Therapist Signature: _____ Date: _____