Health History Information

Name: _____ Date: ____/_____/____

Address:_____City: _____State: _____Zip:_____

Birth Date: ___/____/___ Social Security Number: _____-_____-_____ Gender: ___Female ___Male
Are You: ____Minor ____Single ____Married _____Other
Home Phone: _____ Cell/Work: _____

May we contact you for appointment reminders via text message? __Yes __ No Cell #: _____
Your standard text messaging rates apply in accordance with your current phone provider

Occupation: _____
Emergency Contact: _____ Phone: _____
Physician: _____ Chiropractor: _____
Are you currently under any medical supervision? If so, please explain:

_____
Medications: _____
Surgeries: _____
Recent Injuries: _____
Have you received massage therapy before? Yes No If yes, how long ago? _____
How did you hear about us? ___Internet Search ___Location ___Other ___Current Client*
* Name:_____

Current Health Information

Check any of the following that apply to you presently or recently:

___ Acne
___Aids
___Athletes Foot
___Carpal Tunnel
___Chronic Pain
___Constipation
___Depression/Anxiety
___Eczema
___Fibromyalgia
___Heart Disease
___High Blood Pressure
___Joint/Back Problems/Tension
___History of Blood Clots
___Allergies: to what? _____
___Arthritis: what type? _____
___Cancer: what type? _____
in remission? Yes No
___Diabetes: Type: _____
___Fractures: where? _____
___Headaches: frequency: _____
___Pregnancy (current): Weeks: _____
___Kidney or Lung Disease
___Sprain/Strain/Dislocation
___Stroke: Date: _____
___Thyroid Disorder: Hyper Hypo
___ Other: _____

Preferred Conversation Level
___About My Health Care Only ___Minimal Casual Conversation ___No Preference

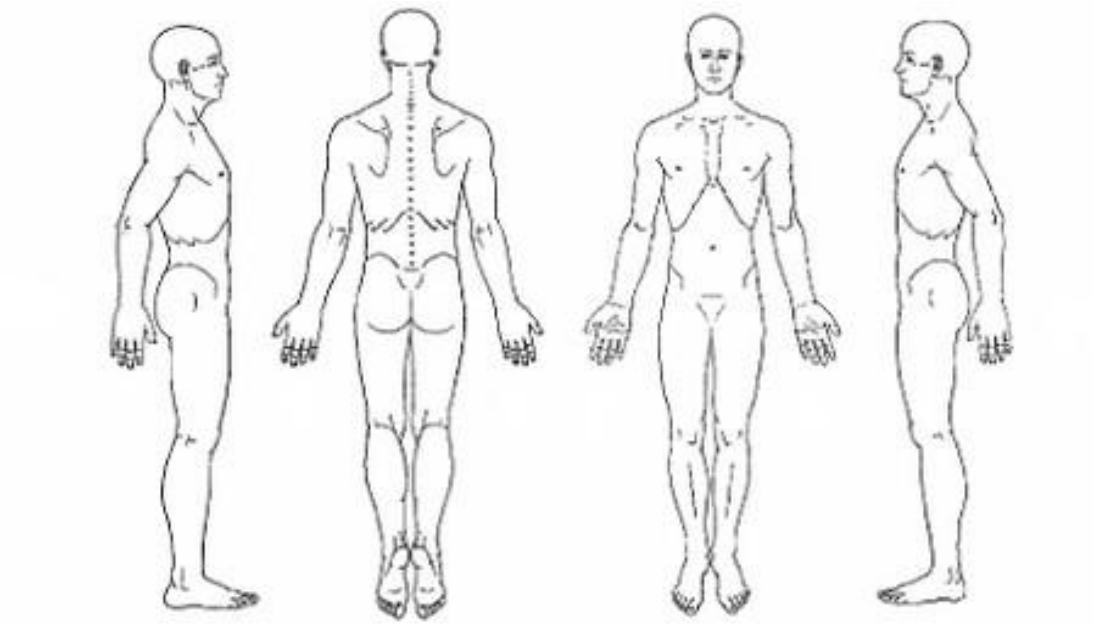
Please Turn Over……

What is your reason for treatment today?

_____

_____

Place an "X" below on areas of tenderness or discomfort.



Initial each of the following if you agree:

____ **8 HOUR CANCELLATION POLICY**: I understand that I am responsible for a **$30 fee** in the event that I am unable to provide **8 hour notice** prior to my appointment. In the event that I miss a scheduled massage I will be billed at the current rate. I agree to these terms and understand that my account will be billed under the conditions stated.

____ LATE POLICY: I understand that if I am late for my scheduled appointment, that time will be deducted from my session and I will be charged for the full session.

____ I understand that chiropractic health care services are offered by a licensed Doctor of Chiropractic, but are in no way practiced by massage therapists, including the practice of medicine. Client records and transactions with the practitioner are confidential.

____ I understand that the therapist has the right to refuse service to anyone due to inappropriate behavior or misconduct and can stop a session at any time. The massage therapist reserves the right to charge for the session time whether or not the services were rendered

CONSENT FOR CARE

It is my choice to receive manual massage therapy and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my therapist of any changes in my health.

Signature: _____ Date: ____/_____/_____