Patient History & Informed Consent for

Remedial Massage Therapy

Name: _____ **DOB:** _____

Occupation: _____

Recreational Activities: _____

Presenting Complaint/s: _____

_____

_____

Please tick any conditions that apply (past or present) and provide details:

- o Blood clots / Stroke .....
- o High / low blood pressure .....
- o Numbness or tingling .....
- o Osteoporosis .....
- o Skin conditions .....
- o Neck injuries / whiplash .....
- o Operations .....
- o Allergies .....
- o Accidents / injuries .....
- o Headaches / migraines .....
- o Cancer .....
- o Other .....

Please list any current medications: _____

_____

Are you currently receiving chiropractic care? **yes / no**

I have informed the Massage Therapist of all of my known physical and medical conditions and medications and I will keep the Massage Therapist updated on any changes.

Patient/Guardian Name: _____

Signed: _____ **Date:** _____