FAMILY CHIROPRACTIC CENTER
20700 CHIPPENDALE AVE SUITE7
FARMINGTON, MN 55024
(P) 651-460-9449 (F) 612-326-9581

ABOUT THE PATIENT

Name _____ Today's Date_____ Birthdate _____ Age_____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____Gender ❑ M ❑ F
Your Employer _____ Type of Work _____
e-Mail Address _____
Emergency Contact _____ phone # _____
How Did You Hear About Us?_____ Whom May We Thank For Referring You?_____

MASSAGE HISTORY

Have you ever had a massage before? ❑ Yes ❑ No
If yes, what type of massage have you experienced? (Swedish, shiatsu, deep tissue, chair, acupressure, etc.)
_____
_____
How often do you receive massage? _____How often would you like to?_____

REASON FOR SEEKING CARE

What type of massage would you like today? (Circle one) Swedish Deep Tissue Hot Stone Sports

Pressure preference: (Place an X on the line) 0 ---------- 10
Very Light Intense Deep Tissue

What are your goals/ expectations for this therapy session? _____
_____
_____

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

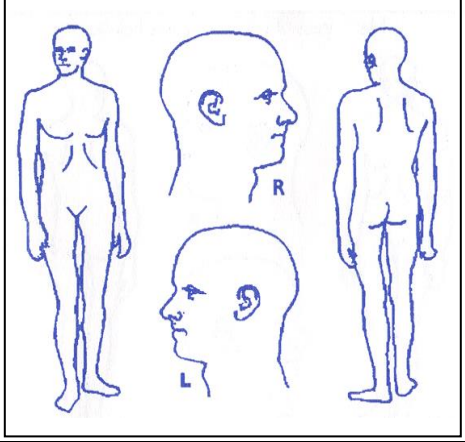
3. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving
_____

4. How did your symptoms begin?_____
5. What makes it worse? _____
6. What makes it better?_____
7. What Doctors have you seen for this?_____
8. Type of treatment:_____
9. Results: _____

NOTES: _____
_____
_____

Are you pregnant?
❑ Yes ❑ No

Please mark All areas of concern.



MEDICAL HISTORY

Do you currently or have you ever had any of the following; (please check)

Past	Present		Past	Present	
❑	❑	Headaches/ migraines	❑	❑	Deep vein thrombosis/ blood clots
❑	❑	Cancer	❑	❑	Heart condition
❑	❑	Joint disorder	❑	❑	High or low blood pressure
❑	❑	Rheumatoid arthritis/ osteoarthritis/ tendonitis	❑	❑	Circulatory disorder
❑	❑	Osteoporosis	❑	❑	Varicose veins
❑	❑	Epilepsy	❑	❑	Atherosclerosis
❑	❑	Diabetes	❑	❑	Easy bruising
❑	❑	Decreased sensation	❑	❑	Recent fracture
❑	❑	Fibromyalgia	❑	❑	Sprains/ strains
❑	❑	TMJ disorder	❑	❑	Current fever
❑	❑	Skin condition	❑	❑	Swollen glands
❑	❑	Open sores or wounds	❑	❑	Recent accident or injury

Are you currently taking any medication? ❑ Yes ❑ No

If yes, please explain: _____

Do you have any allergies? (Seasonal, oils, lotions, fruits, nuts, etc.) ❑ Yes ❑ No

If yes, please explain: _____

Is there anything else about your health history that you think would be useful for you massage therapist to know to plan a safe and effective massage session for you? _____

_____

CANCELLATION POLICY

Should I cancel or miss an appointment with less than a 12 hour notice, I acknowledge that I will be charged 50% of my scheduled appointment. This amount must be paid prior to my next schedule appointment. We strive to create and maintain a professional and respectful environment. In turn, we appreciate your business and respect.

Please Initial _____

READ AND SIGN

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date_____