Classic Massage History/Consent

Date: _____

Full Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City: _____ Cell Phone: _____

State: _____ Zip: _____ e-mail address: _____

Age: _____ Sex: M F Birth Date: _____ Marital Status: M S W D P

Occupation (List Activities): _____

Who can we thank for referring you to our office? _____

What is your goal for massage? _____

What are the appropriate areas of concern? (Please mark an **H** for High, **M** for Medium, or **L** for Low)

____ Headache	____ Upper Back	____ Knee	____ Other _____
____ Neck/Shoulder	____ Middle Back	____ Foot/Ankle	____ Other _____
____ Arms	____ Lower Back	____ Leg/Thigh	____ Other _____

Massage History

Have you had a professional massage before? ❑ Yes ❑ No When? _____

What type of Massage do you like? _____

How often do you get massage? _____

Have you had any problems with a previous massage or massage therapist? ❑ Yes ❑ No If Yes, Please explain. _____

Do you have any allergies or sensitivities to oils, lotions, or scents? _____

Health History

Have you ever had or do you now have any of the following?

❑ Skin Disorders	❑ Open Wounds	❑ Circulation Problems	❑ Leg Problems
❑ High Blood Pressure	❑ Stroke	❑ Infections	❑ AIDS or HIV
❑ Extremity Problems	❑ Blood Clots	❑ Diabetes	❑ Surgical Stints
❑ Lung Problems/Congestion	❑ Heart Disease/Attack	❑ Fluid Retention	

Major Surgery: ❑ Back Surgery ❑ Hernia ❑ Hysterectomy ❑ Other _____

Have you ever had any injuries? (broken bones, torn/sprained ligaments, etc.) ❑ Yes ❑ No If Yes, Please explain. _____

Have you ever been diagnosed with cancer?: ❑ Yes ❑ No (Approx. Date/Description) _____

Females: Are You Pregnant? ❑ Yes ❑ No ❑ Not Sure Breast Implants: ❑ Yes ❑ No

Classic Massage

I consent to massage at Classic Chiropractic. I certify that the above information is complete and correct.

Signature of Massage Client _____ Date: _____

Therapist Signature Upon Review: _____ Date: _____

Therapist's Notes: _____