SHOREWOOD FAMILY
CHIROPRACTIC

NEW MASSAGE PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Address: _____ City: _____ State: ____ Zip code: _____

E-mail: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Allergies: _____

Medication: _____

Do you have any Orthopedic (muscle or bone) injuries?: _____

Have you had a massage before? Yes____ No____ What pressure do you like: Light ____ Moderate _____ Deep _____

Do you suffer from Chronic Pain? Yes ____ No____
What makes it better? _____ Worse? _____

Are You Pregnant? Yes ____ No ____

Indicate any conditions you have / had:

☐ Migraine headaches	☐ Arthritis	☐ Cancer	☐ Fibromyalgia
☐ Stroke	☐ Blood Clots	☐ Numbness	☐ High/Low Blood Pressure
☐ Neuropathy	☐ Sprains/Strains		

Are there any areas you **do not** want massaged?: _____

What are your treatment goals? _____

I understand that the massage given to me is for stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons stated here_____. I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment. I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have. I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

Signature: _____ Date: _____

I understand that massage is not a covered service by my insurance and take full financial responsibility for any charges accrued during my massage.
I have read and agree to the above statement.

Signature: _____ Date: _____

Please mark any areas of concern on the diagram.