Personal Information

Name _____ Occupation _____

Phone (day) _____ (evening) _____

Address _____ City, State, Zip _____

Email _____Date of Birth _____
SS#_____-____-_____

Emergency Contact _____ Phone _____

Primary Care Physician_____ Phone _____

Other providers you have seen (Check all that apply) ☐ Chiropractor ☐ PT ☐ Acupuncturist
☐ Orthopedist ☐ Neurologist/Neurosurgeon ☐ Other:_____

If yes, who and date last seen_____

How did you hear about us? _____

Massage Information

Have you ever had a professional massage before? ☐ Yes ☐No

If yes, how often to you receive massage therapy? _____

What type of massage are you seeking today? ☐ relaxation ☐ Treating an injury or specific condition
☐Part of my wellness lifestyle

Do you have a style or pressure preference? ☐ Yes ☐ No

Specify: ☐ light pressure ☐ medium pressure ☐ deep pressure ☐ energy work ☐ other_____

Are you sensitive to fragrances or perfumes? ☐ Yes ☐ No

Do you have sensitive skin? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

If so, what type(s)? _____

What are your common areas of concern, pain or tension?

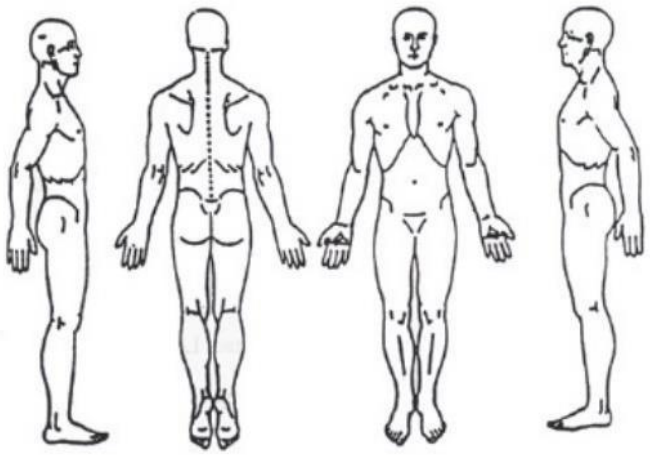
_____

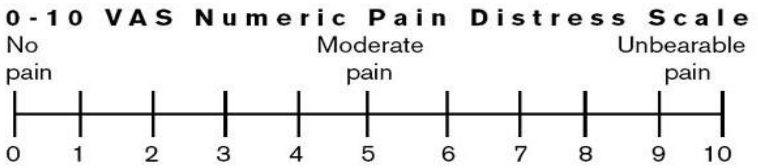
_____

_____

(Continued on back)

Circle any specific areas you would like the massage therapist to concentrate on during the session:





What are your goals of massage are you seeking today? ☐ relaxation ☐ wellness☐ injury related ☐ deep tissue/therapeutic ☐ pregnancy ☐ integrated bodywork ☐ other _____

Medical History

Are you currently taking any prescription medication? If so, what? _____

_____

Please indicate any conditions that you have had or currently have:

☐Headaches, migraines	☐Heart/circulation problems	☐Varicose veins	☐Fibromyalgia
☐Allergies, sensitivity	☐Joint replacement/surgery	☐Pregnancy	☐Numbness
☐Arthritis, tendonitis	☐High/low blood pressure	☐Blood clots	☐Sprains, strains
☐Cancer, tumors	☐Major accident	☐Neck/back injuries	☐Recent injuries
☐TMJ problems	☐Lack of or reduced feeling/sensation	☐Diabetes	☐Surgeries
☐Abnormal skin condition		☐Paralysis	☐Other _____

Explain any conditions that you have marked above: _____

_____

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist. I informed the massage therapist about all my health conditions. I understand that Sea Change Family Chiropractic is not responsible for the potential problems with me during or after the treatment. With my present statement I irrevocably sign away claiming any damages against Sea Change Family Chiropractic.

Signature _____ Date _____