

Massage Client Information

Thank you for choosing Caledonia Chiropractic Clinic
If you have any questions of concerns, please do not hesitate to
ask for assistance, we are happy to help.

Full Name: _____ Date: _____

Address: _____ Apt#: _____

City: _____ State _____ Zip Code: _____

Date of Birth: _____ Email Address: _____

Home Phone: _____ Business/Cell Phone: _____

Do you prefer to receive calls at: Home Work Cell Any

Person to contact in case of emergency: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Occupation: _____ Referred By: _____

Have you ever experienced professional massage before: Yes No

Are you here for: Relaxation Massage Therapeutic Massage

Are You Pregnant: No/NA Yes my due date is: _____

Hospitalization: _____ When: _____

Medications: _____

Injuries/Accidents that are still affecting you:

Appliances (Screws, pacemakers, etc):

Broken Bones: _____ When: _____

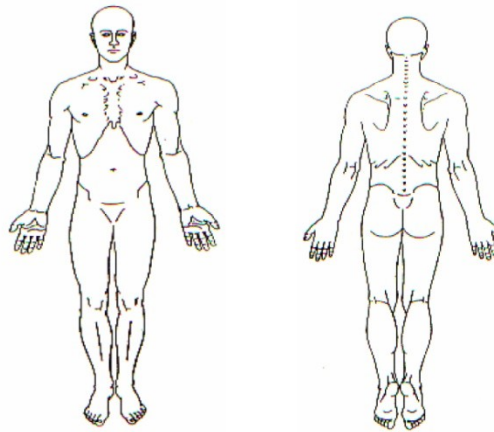
Please list any spine or back injuries, including any disc problems such as bulging, rupture, herniated, and the location. Also any treatments you are currently undergoing:

Massage Patient Information - Page 2

For the following conditions, please place a √ in the past column if you have had the condition in the past. If you currently have a condition, please place a √ in the present column:

Past	Present		Past	Present	
		Headache/Migraines			Bone or Joint Disease
		Neck/Shoulder pain			Arthritis, Bursitis, or Gout
		Upper back pain			Osteoporosis
		Mid back pain			Fibromyalgia
		Low back pain			Varicose veins
		Wrist pain			Heart condition
		Hand pain			Respiratory condition
		Digestive disorder			Anxiety or stress
		Hip/leg pain			Blood clots
		Ankle/foot pain			Diabetes
		Sprains			High blood pressure
		HIV/AIDS			Cancer
		Hepatitis Type:			

Please indicate with an X on the drawing below the areas where you are feeling discomfort:



I understand that massage is not a replacement for medical care and that no diagnosis will be made. I will keep my therapist informed of any medical conditions to make sure there are no contraindications for massage. I know if I fail to do so, my therapist is not liable for any problems arising from my massage. I also understand that any illicit or sexual suggested remarks made by myself will result in termination of my session and any further therapy.

Missed Appointment Policy:

24 HOUR NOTICE is required for cancelation or rescheduling an appointment. If you are using a Gift Certificate and miss a scheduled appointment or make a cancellation without 24 hour notice, your certificate will be void.

Signature: _____ Date: _____

****Gratuity is not included****