



AMERIHEALTH

CHIROPRACTIC & WELLNESS

Massage Therapy Client History Form

In order to maximize the effectiveness and safety of the massage sessions, please take the time to carefully fill out this questionnaire. This information will be treated confidentially. Your feedback will be appreciated during and at the end of the massage to help ensure you receive the maximum benefits from your session.

Date of first visit _____

Referred By _____

Name _____

Home or Cell Phone _____

Address _____

Email _____

Occupation _____

Have you had a professional massage before? Yes No

Last Massage Date _____

Have you had chiropractic before? Yes No

Currently seeing one? Yes No

Are you currently a patient of Amerihealth Chiropractic? Yes No _____

What is your goal/concern for today's session? _____

Please answer the following questions by circling the appropriate answer:

- | | | |
|--|-----|----|
| 1. Do you wear contact lenses | Yes | No |
| 2. Do you wear dentures? | Yes | No |
| 3. Are you pregnant? | Yes | No |
| 4. Do you have varicose veins? | Yes | No |
| 5. Do you have high blood pressure? | Yes | No |
| 6. Do you have or have you ever had a heart problem? | Yes | No |
| 7. Have you ever had cancer? | Yes | No |
| 8. Do you have osteoporosis? | Yes | No |
| 9. Have you ever had surgery or broken a bone? | Yes | No |
| 10. Do you have rheumatoid arthritis? | Yes | No |
| 11. Do you have any allergies? | Yes | No |

Notes: _____

Do you have any other pertinent medical condition not mentioned? _____

Have you been in any recent car accident? Yes No When? _____

Did you sustain any injuries from the accident? Yes No _____

I, _____, understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals, nor does the massage therapist perform any spinal manipulations. It has been made clear to me that massage therapy is not a substitute for medical examination or diagnosis and it is recommended that I see a physician for any physical ailment I might have. I, the client, allow the massage therapist to perform appropriate massage therapy techniques needed to improve my condition and help achieve the goals of the session.

Signature (client) _____ Date _____

Signature (licensed massage therapist) _____