SHILOH CHIROPRACTIC MASSAGE – *Confidential Client Information* *DATE*

Name:_______________________________________ Birth Date:______________

How did you hear about us? _______________________________ Phone1:_____________________________ cell / home / work

Address: ____ Phone2:_____________________________ cell / home / work

City/State/Zip: ____ Have you had alcohol within 24 hours? [YES | NO]

Email: ____ We won't sell, trade or give your email away. We won't SPAM you.

Hobbies:____

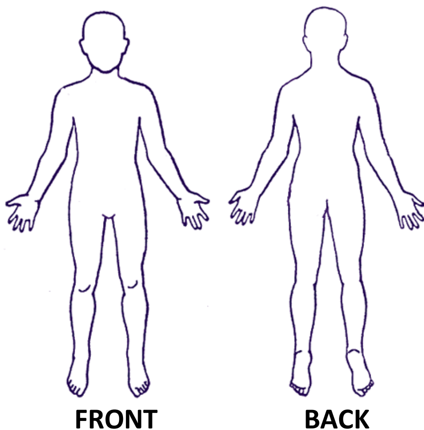
Do you sit for long hours at a work station, computer or car? (Explain) ____

What kind of stress do you have: ____

How is this affecting you? [ ] Muscle Tension [ ] Anxiety [ ] Insomnia [ ] Irritability [ ] _________________________________

What are your goals for your massage session? ____

Indicate which areas bother you below:



HISTORY:

Have you been massaged before? [yes / no] Do you bruise easily? [yes / no]

I prefer the following pressure: [ ] Light [ ] Heavy [ ] Deep Trigger [ ] Unsure

Do you wear: [ ] Contacts [ ] Dentures [ ] Hearing Aid

Do you: [ ] Have a pacemaker [ ] Wear a patch [ ] Use prosthetics

Do you have difficulty lying on your back, side or stomach? ___________________

Do you have allergic reactions to any oil, lotion, ointment, gel or other? _________

Explain: ____

Are you under medical supervision? _______________________________________

Any medications? ____

Any surgeries or accidents w/in 24 months? _________________________________

Are you or could you be pregnant? ____ Trimester# ____ Due: ________________

Each time we will generally massage the following; which of the following would you like extra time spent on?

__Neck __Low Back __Legs __Face __Chest (excluding breast tissue)

__Arms __Feet __Stomach __Hands __Buttock __Scalp __Upper Back

Any area(s) you want us to exclude? ____

I have answered the above questions to the best of my ability. I acknowledge that massage therapy does not include medical diagnosis and that I should see an appropriate healthcare professional to diagnose and treat medical problems. I give my consent for the massage sessions.

Signature: ____ Date: __________________

Parent if under 18: ____ Date: __________________