Massage History

Personal Information

Name: _____ Date of Birth: _____ Age: _____ Sex: ❑ M ❑ F
Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ Landline: _____ SS#: _____
E-Mail Address: _____
Employer: _____ Work Phone: _____ Occupation: _____
Marital Status: ❑ M ❑ S ❑ W ❑ D Spouse's Name: _____
In Case of Emergency Notify: _____ Phone: _____
Who is your family physician? _____
By whom were you referred to this office? _____

Complaint History

What is the purpose of the visit today? (Please include areas of complaint, pain, tension and stress): _____
_____

Have you had **professional massage therapy before**? ❑ Yes ❑ No

Past History

Have you had any **major or recent injuries** that the therapist should be aware of prior to your massage?
❑ Yes ❑ No If yes, please describe: _____

Have you had any **surgeries**? ❑ Yes ❑ No If yes, please list: _____

Do you have any **allergies or skin problems** that you are aware of?
❑ Yes ❑ No If yes, please list: _____

Do you wear **contact lenses, dentures or any other removable medical devices**? ❑ Yes ❑ No

Do you have any of the following **cardiovascular problems? Mark any that apply**
❑ Heart problems ❑ High blood pressure ❑ Blood clots ❑ Varicose veins ❑ Other _____

Do you have any form of **arthritis**? ❑ Yes ❑ No If yes, please describe: _____

Do you have any **spinal problems**? ❑ Yes ❑ No If yes, please describe: _____

Have you ever or are you presently experiencing any **other conditions** that we should be aware of prior to your massage?
❑ Yes ❑ No If yes, please describe: _____

Have you **recently or are you presently** taking any **prescription/over the counter medication OR nutritional supplements**?
*We can photocopy an existing list or you may attach a sheet of paper if you are taking many medications or supplements.

❑ Yes ❑ No If yes, please list them and reason for taking them: _____
_____

For females only:
Are you **currently pregnant?** ❑ Yes ❑ No If yes, how far along are you? _____
If yes, do you have any concerns with your pregnancy? ❑ Yes ❑ No Is this your first child? _____

I, _____, understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and flow. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that this massage is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailments that I might have.
Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature _____ Date _____

Natural Health Family Chiropractic

Appointment Policy for Massage

It is our desire and aim to be as available as possible to our massage clients. We often have a wait-list for appointments, which we work diligently to accommodate. Missed or short-notice cancellations prevent us from allowing room for those on our wait list.

We kindly ask for 24 hour notice or more to cancel or re-schedule your appointment. If an appointment is canceled or re-scheduled less than 24 hours, or if the appointment is missed with no notice, we reserve the right to charge the full amount of the massage scheduled. In addition, if you are late for a massage appointment, you may be responsible to pay the full amount of that massage.

Please try and allow yourself at least 5-10 minutes prior to your appointment time so that you can relax and enjoy your full massage.

** For your convenience, you will receive a text reminder for your appointment approximately 24 hours prior to your appointment **

I have read and understand the NHFC Appointment Policy.

Patient Signature: _____Date:_____

Natural Health Family Chiropractic
And Massage Therapy

Dr Mark Lindholm
Dr Joshua Martens
Dr Ryan Hartman

PRIVACY NOTICE ACKNOWLEDGEMENT

EFFECTIVE DATE:

This Notice is effective as of April 14th, 2003.

ACKNOWLEDGEMENT:

I acknowledge that I have received a copy of the practice's Privacy Notice that has an effective date of April 14th, 2003.

_____ _____
Name of Individual (printed) Signature of Individual

Date Signed _____/ _____/ _____