



Client Information Form

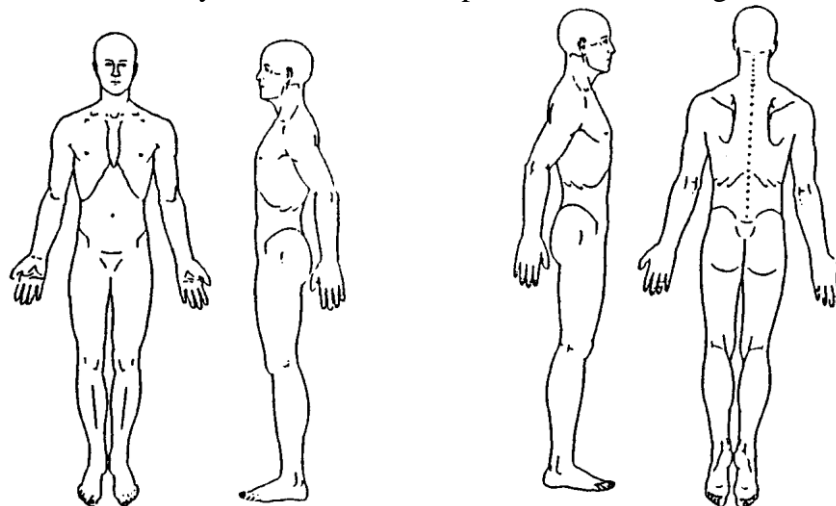
Name _____ Date of Birth _____ Age _____
 Address _____ City _____ ZIP _____
 Email _____
 Telephone (Day) _____ (Evening) _____
 Emergency Contact Person _____ Phone _____
 Physician _____ Phone _____
 List Any Prescribed Medications _____

Please answer the following questions by circling the appropriate answers:

Have you had a professional massage before?	YES	NO
Do you wear contact lenses or dentures?	YES	NO
Are you sensitive to perfumes, lotions or oils?	YES	NO
Do you have any skin problems or allergies?	YES	NO
Have you experienced any illness or injuries lately?	YES	NO
Do you have any heart problems?	YES	NO
Do you have high blood pressure?	YES	NO
Do you have varicose veins?	YES	NO
Do you have arthritis, osteoporosis, or spinal problems?	YES	NO
Are you pregnant?	YES	NO
Do you exercise regularly or participate in any sports?	YES	NO
Do you have any other health problems that I should be aware of?	YES	NO

Please provide a brief explanation for any YES answers on the reverse side.

Mark any areas of tension or soreness you would like therapist to address on figures below.



I understand that the massage therapy given here is for the purpose of reduction of pain and stress, relief from muscular tension or spasm, and for the promotion of circulation and lymph activity. I understand that a 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 massage therapy is not a substitute for medical examination and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I may have. A massage therapist must be made aware of existing physical conditions, hence 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 _____
 MASSAGE THERAPIST _____



ADVANCED
CHIROPRACTIC
CENTER, INC.

2508 Hillsboro Ave. N., Golden Valley, MN 55427

Name _____ Date of Birth _____

Please answer any questions that apply to you

My pain is (circle) *mild moderate severe* *seldom intermittent frequent constant*

List activities that ↑ your pain _____

List activities that ↓ your pain _____

How has this physical problem affected your daily activities? _____

Summarize your goals for massage treatment / What you would like to get out of this? _____

Additional Notes On “Yes” Questions (from other side)