FALL RIVER CHIROPRACTIC

Date:_____

Name:_____ Birth Date:_____

Address:_____ HM Ph#:_____

City:_____ Postal Code:_____ WK Ph#:_____

Occupation:_____ Cell Ph#:_____

Physician's Name and Ph#:_____

Have you had massage before? **Y N** E-Mail Address:_____

Other Therapies? (ie.Chiropractic, Physiotherapist, etc)_____

Emergency Contact:_____ Ph#:_____Relationship:_____

Please check any boxes which apply:

Cardiovascular System	**Other Conditions**	**Female Concerns**
o Aneurysm o High blood pressure o Low blood pressure o Heart disease o Stroke o Varicose veins o Bruise easily o Pacemaker o Phlebitis	o Headaches/migraines o Anxiety o Depression o Difficulty sleeping o Thyroid condition o Bowel/digestive o Diabetes o Epilepsy o Cancer o Arthritis	o Painful menstruation o Menopausal problems o Caesarean section o Endometriosis o Pregnant (or possibility) Due date:_____ Other (please specify): _____ _____
Skin and Infections	**Respiratory System**	**Medications**
o Plantar warts o Eczema o Psoriasis o Fungal infection (ie. athletes foot) o Herpes simpex Others(please specify): _____ _____	o Bronchitis o Asthma o Emphysema o Sinusitis o Chronic cough o Breathing problems Specify: _____ _____	Please indicate type, what it is for and the times that it is taken: _____ _____ _____ _____ _____ _____ _____ _____

Do you frequently experience: o Stress o Headaches o Back or Neck Pain

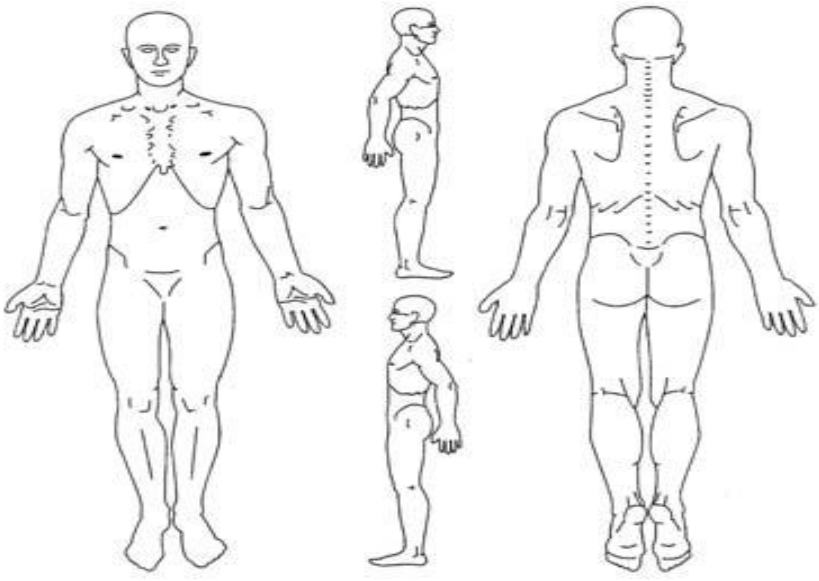
In the past 2 years have you had: o Surgery o Broken Bones o Cardiac Problems

If you are experiencing pain please specify a level on the scale:

MILD 1.....2.....3.....4.....5.....6.....7.....8.....9.....10 SEVERE

Please indicate on the diagram below where you have pain or discomfort:

xxx Pain /// Discomfort <<< Numbness



What do you hope to achieve through Massage Therapy: _____

_____

_____

I,_____, consent to massage therapy treatments as described by the massage therapist. I also verify that the information given on this form is true and reflects my past and present health status. Should there be any change in my health I will inform my therapist before treatment.

I understand that Massage Therapists do not diagnose illness or prescribe medications, and that my treatment will be in the context of relaxation, relief of muscular tension or pain, and improving circulation.

I agree to pay for all scheduled appointments that I am unable to keep unless I notify my Massage Therapist at least 24 hours in advance. Should I arrive late I will pay for a full session although it will end at the originally scheduled time.

Signed:_____ Date: _____