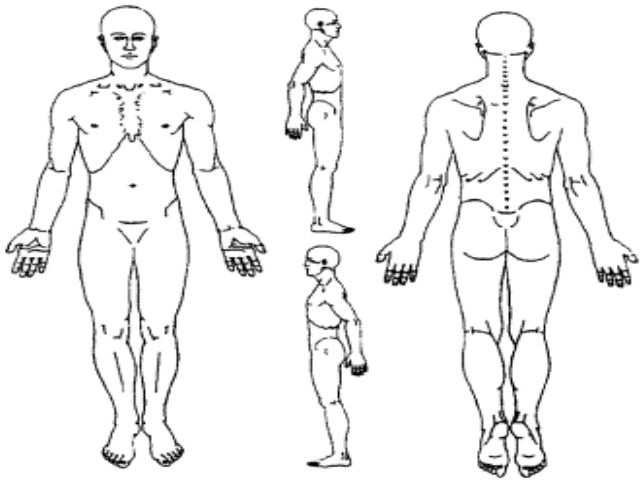
Family Chiropractic of Lederach, LLC

CLIENT HEALTH HISTORY

Name: _____ Date of Birth: _____ Age: _____
Address: _____
Phone: _____ Email: _____ (Used for Confirmation)
Occupation: _____ Emergency Contact: _____ Phone: _____

1. **Primary area of concern:**



2. **How did this develop? _____**
3. **What makes it worse? _____What makes it better? _____**
4. **Does this condition interfere with: Work? ____ Sleep? _____ Recreation? _____**
5. **Have you ever had massage therapy before? _____ Where? _____**
6. **Are you under chiropractic care? _____**
7. **Have you had any recent injuries? _____**
8. **Are you taking any medications : _____**
9. **Surgeries and when: _____**
10. **Any broken bones in the past two years? _____ Which ones? _____**
11. **Are you pregnant? _____ If yes, are you in your 1st trimester? _____**
12. **Do you have any skin conditions, allergies, or sensitivities? ____ Please explain: _____**
13. **Please check any of the following conditions if you have had them recently:**

__ Lower back pain	__Spina Bifida	__ Hepatitis	__ Edema
__ Herniated Disk	__ Varicose Veins	__ Fainting Spells	__ Diarrhea
__ Neck Pain	__ Sciatica	__Blood Clots	__ Fatigue
__ Diabetes	__ Insomnia	__Heart Conditions	__ HIV
__ Depression	__ Loss of Balance	__Headaches	__ Sinusitis
__ Mid Back Pain	__ Shoulder Pain	__ Skin Disorders	__ Arthritis
__ TMJ Dysfunction	__ Shortness of Breath	__ High/ Low Blood Pressure	__ Cancer
__ Numb Hands	__ Numb Feet	__ Constipation	__ Allergies
__ Abdominal Hernia			

14. **Do you have any other medical condition (major or minor) not already covered herein that you think the therapist should be aware of? If so please explain: _____**

_____

IMPORTANT: PLEASE READ CAREFULLY

If you have a specific medical condition or specific symptoms, massage work may be contraindicated. A referral from your primary care provider may be required prior to services being provided. Please take a moment to carefully read the following information and sign where indicated.

I understand that the massage work I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and / or strokes may be adjusted to my level of comfort. I further understand that massage therapy should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or the qualified medical specialist of any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the sessions(s) given should be construed as such. Because massage therapy is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made to me will result in immediate termination of the session. **Must be 18 or older, or parent/guardian signature is required.**

Client Signature: _____ Date: _____

(Parent/guardian signature if applicable)

Amount of pressure desired for your massage:

Gentle_____ Moderate _____ Deep _____