Hollenbach Family Chiropractic
Creating a Healthy Lifestyle

Massage Therapy Health History Form

Appointment Date:_____

Client Name:	
Client Address:	
Client Phone:	
Client Email:	
Emergency Contact Name:	
Emergency Contact Phone	
Client Date of Birth:	
Client Age:	
Physician's Name:	
Physician's Phone:	

What type of pressure do you prefer? Light Medium Firm
Are you sensitive to touch. if so where?
_____

What are your goals for receiving massage therapy? Pain Relief Relaxation Improved Athletic Performance
If receiving massage therapy to address pain relief please list your symptoms/issues:
_____

Do these symptoms interfere with your activities of daily living? CIRCLE: **Exercise Sleep Work**
Are you pregnant? Yes No
Do you wear contact lenses? Yes No
Do you wear dentures? Yes No
Are you currently taking blood thinners, pain medications or insulin, if so, please indicate
_____
Do you have any allergies? If so, please list. _____
Do you have cancer or are you in remission? Please indicate: _____
Did you have a lumpectomy? _____
Other medical conditions, or are you taking any medications I should know about? _____
_____

Please circle if you have experienced the following:

Stress	Diabetes	Bruise Easily	Frequent Headaches
Arthritis	High Blood Pressure	Epilespy	Suffer from Back Pain
Varicose Veins	Osteoporosis	Joint Swelling	Digestive Conditions
Veritgo	Dizziness/Ringing in ears	Fibomyalgia	Scoliosis

I have read and understand the possible contraindications to massage therapy. I further understand that massage should not be construed as a substitute for medical care. I agree to update the massage therapist in written correspondence as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.
I understand that the practice of Massage Therapy is a separate and distinct business entity than therapy from Hollenbach Family Chiropractic provided by Dr. James Hollenbach at 250 Main Street, Madison, NJ 07940
Patient's Signature
Please Print and Sign Patient Name: _____