

# Massage Center at Goshorn Chiropractic

585-671-6688

## Massage Client Information

Name: \_\_\_\_\_ Referred By: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Under Current Medical Care? Y N If Yes, For What Condition: \_\_\_\_\_

Areas Of Complaint, Pain, Stress, Tension, Soreness: \_\_\_\_\_

Quality Of Pain (eg. Sharp, Dull, Tender, Radiating): \_\_\_\_\_

What Makes Problem Better? \_\_\_\_\_

What Makes Problem Worse? \_\_\_\_\_

Have You Received Bodywork Before? Type? Frequency?

Any Current Illness Or Infectious Disease(s)? \_\_\_\_\_

Current Medications (Include Dosage And Frequency): \_\_\_\_\_

Do You Exercise Regularly Or Participate In Sports? What? Frequency? \_\_\_\_\_

What Do You Expect From This Massage Session? \_\_\_\_\_

### Medical History:

\_\_\_ Arthritis      \_\_\_ Heart Disease      \_\_\_ Cancer      \_\_\_ Hypertension

\_\_\_ Varicose Veins      \_\_\_ Phlebitis      \_\_\_ Thrombosis      \_\_\_ Hypotension

\_\_\_ Headaches      \_\_\_ Constipation      \_\_\_ Diarrhea      \_\_\_ Bloating/Gas

\_\_\_ Insomnia      \_\_\_ Anemia      \_\_\_ Fatigue      \_\_\_ Nausea

\_\_\_ Skin Diseases      \_\_\_ Asthma      \_\_\_ Bronchitis      \_\_\_ Bursitis

\_\_\_ Diabetes      \_\_\_ Hypoglycemia      \_\_\_ Depression      \_\_\_ Excess Energy

\_\_\_ Sinus Problems      \_\_\_ Hepatitis      \_\_\_ Impaired or Excessive Urination

\_\_\_ Night Sweats      \_\_\_ Blurred Vision      \_\_\_ Hearing Issues

\_\_\_ Cold/Hot/Painful (Where)? \_\_\_\_\_

\_\_\_ Neck Pain      \_\_\_ Back Pain (Where)? \_\_\_\_\_

Other: \_\_\_\_\_

Broken Bones, Joint Dislocation, Injury, Surgery (What/When)? \_\_\_\_\_

\_\_\_\_\_  
Numbness (Area)? \_\_\_\_\_

Allergies (Food, Medicine, Environmental): \_\_\_\_\_

Pacemaker or Other Artificial Devices? \_\_\_\_\_

**For Women:** Are You Pregnant? Y N

If Yes, How Many Months? \_\_\_\_\_

*(See Back Page)*

I, \_\_\_\_\_, understand that Massage Therapy is given here for the purpose of stress reduction, relief from muscular tension or spasm, increasing circulation and/or balancing energy 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 therapy is not a substitute for medical examinations and/or diagnosis, and that it is recommended that I see a physician for any physical ailment 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.

Client Signature \_\_\_\_\_ Date: \_\_\_\_\_

Massage Therapist \_\_\_\_\_ Date: \_\_\_\_\_