



Massage Therapy Client History Form

In order to maximize the effectiveness and safety of the massage sessions, please take the time to carefully fill out this questionnaire. This information will be treated confidentially. Your feedback will be appreciated during and at the end of the massage to help ensure you receive the maximum benefits from your session.

Date of first visit _____ Referred By _____

Name _____ Home or Cell Phone _____

Address _____ Email _____

Occupation _____

Have you had a professional massage before? Yes No Last Massage Date _____

Have you had chiropractic before? Yes No Currently seeing one? Yes No

Are you currently a patient of Amerihealth Chiropractic? Yes No _____

What is your goal/concern for today's session? _____

Please answer the following questions by circling the appropriate answer:

- 1. Do you wear contact lenses? Yes No
2. Do you wear dentures? Yes No
3. Are you pregnant? Yes No
4. Do you have varicose veins? Yes No
5. Do you have high blood pressure? Yes No
6. Do you have or have you ever had a heart problem? Yes No
7. Have you ever had cancer? Yes No
8. Do you have osteoporosis? Yes No
9. Have you ever had surgery or broken a bone? Yes No
10. Do you have rheumatoid arthritis? Yes No
11. Do you have any allergies? Yes No

Notes: _____

Do you have any other pertinent medical condition not mentioned? _____

Have you been in any recent car accident? Yes No When? _____

Did you sustain any injuries from the accident? Yes No _____

I, _____, understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals, nor does the massage therapist perform any spinal manipulations. It has been made clear to me that massage therapy is not a substitute for medical examination or diagnosis and it is recommended that I see a physician for any physical ailment I might have. I, the client, allow the massage therapist to perform appropriate massage therapy techniques needed to improve my condition and help achieve the goals of the session.

Signature (client) _____ Date _____

Signature (massage therapist) _____