MASSAGE CLIENT INFORMATION

In order to maximize the effectiveness and safety of our massage sessions together, we ask that you take the time to fill out this confidential questionnaire carefully.

Name: _____

Date: _____ **Date of Birth:** _____ **Referred by:** _____

Address: _____

City, State, Zip: _____

Phone (cell): _____ **(work):** _____ **(home):** _____

Email: _____

Age: _____ **Occupation(s):** _____

Emergency Contact: _____ **Phone:** _____

What brings you here today? _____

Are you currently under chiropractic care? Yes / No Doctor: _____

If no, if chiropractic care could help you, would you be interested in a complementary consultation? Yes / No

Is there any area where you would like extra time spent? Is there any area where you have muscle pain/stiffness/tension (neck, low back, shoulder, other)? _____

_____

What is your previous experience with professional massage? _____

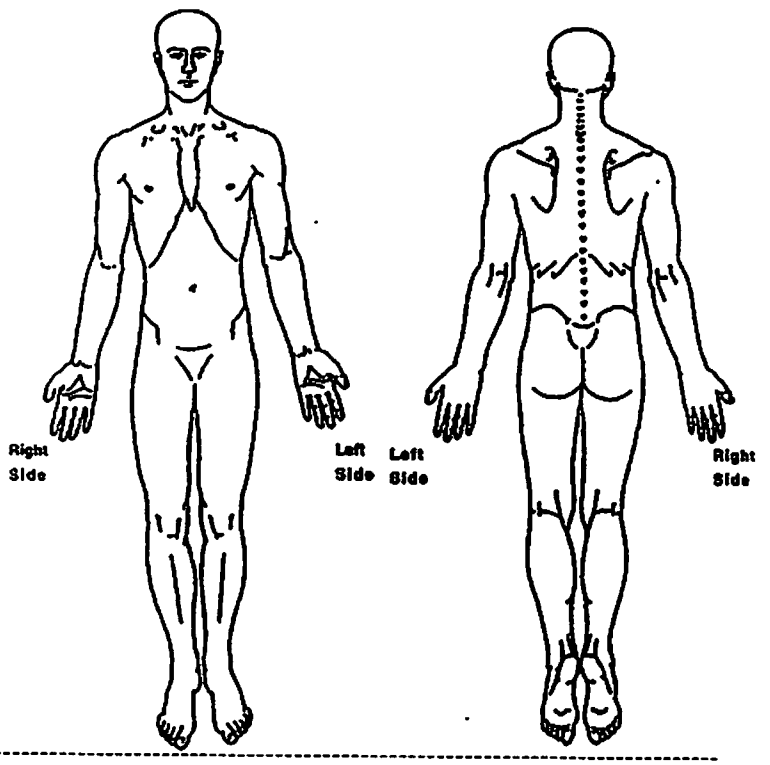
_____

Body Diagram

Please use the diagram at right to draw in any areas of complaint or concern. If no problem areas, please leave blank.

Use these symbols if necessary:

XXX Sharp
000 Dull
/// Burning Pain
AAA Numbness
*** Pins and needles or tingling



Height: _____
Weight: _____

Cummins Chiropractic & Wellness
4122 Factoria Blvd SE, SUITE 202, Bellevue WA 98006 || Phone (425) 590-9158 || Fax (425) 458-0100

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First & Last Names_____ Today's Date_____/_____/_____

Medical History - Please indicate below any significant medical problems, as such conditions can influence the type and/or depth of work done in any given area. Thank you.

Exercise (types and frequency) _____

How much sleep on a regular basis? _____ Notes: _____

Posture assumed most of day _____

Regular bowels? Yes / No Notes: _____

_____ Allergies: _____

_____ Skin condition (acne, rash, allergies, skin cancer, other): _____

_____ Lymphatic condition (swollen glands, lymphoma, lymphedema, other): _____

_____ Recent injury or accident (whiplash, sprain, deep bruise, other): _____

_____ Circulatory condition (heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis, other):

_____

_____ Neurological condition (sciatica, numbness/tingling of any area of skin, stroke, epilepsy, other):

_____

_____ Joint problems, pain, or stiffness (osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, sacroiliac problems, other): _____

_____ Can you lie comfortably on your stomach?_____ Can you lie comfortably on your back?_____

_____ Bone conditions (osteoporosis, previous fracture, cancer, other): _____

_____ Headaches (migraines, PMS, tension, cluster, other): _____

_____ Emotional difficulties (depression, anxiety, psychotic episodes, other): _____

_____ Stress : _____

_____ Previous surgery, please state type and date: _____

_____

_____ Other medical considerations: _____

_____ List any medications or supplements you are currently taking: _____

_____

Tobacco _____ Alcohol _____ Caffeine _____

_____ Female: Are you pregnant? Yes / No

_____ Do you have any body piercings that would be affected by heat (such as belly piercings)?

Name of Health Care provider (not Insurance Co.): _____

Facility Name: _____ Phone: _____

Signature of Client _____ **Date** _____

(Signature of parent or guardian if client is a minor)