

# Massage & Body Work at *The* Mantonya Chiropractic Centers

Improving Lives with Expert Healthcare since 1971.

Name:

First \_\_\_\_\_ M \_\_\_\_\_ Last \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ PO Box \_\_\_\_\_

Phone (H)(\_\_\_\_\_) \_\_\_\_\_ (Cell)(\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ S.S.# \_\_\_\_\_

Marriage Status: M ( ) S ( ) W ( ) D ( ) Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Referred by \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Their phone # (\_\_\_\_) \_\_\_\_\_

**If you are pregnant, you must complete a pregnancy information form now to determine your eligibility for massage.**

Is this your first Massage? Yes  No

What results would you like from your massage session?  Relaxation/stress reduction  Decrease pain/pain management

Decrease muscle stiffness  Increase mobility  General wellness  Other \_\_\_\_\_

Specify and prioritize problem area to be focused on. \_\_\_\_\_

Any body areas you prefer not to be massaged? \_\_\_\_\_

How would you rate your state of health?  Excellent  Good  Fair  Poor

Your Physical Activities \_\_\_\_\_

Are you currently under the care of a physician? Yes  No

If so, for what reason? \_\_\_\_\_

Are you currently taking **ANY MEDICATIONS** (including over the counter and herbal/nutritional supplements)

Y  N  If so, what medications and for what reasons. \_\_\_\_\_

List Allergies \_\_\_\_\_ List Any Surgeries \_\_\_\_\_

Accidents? <5 yrs. Ago \_\_\_\_\_ >5 yrs ago \_\_\_\_\_

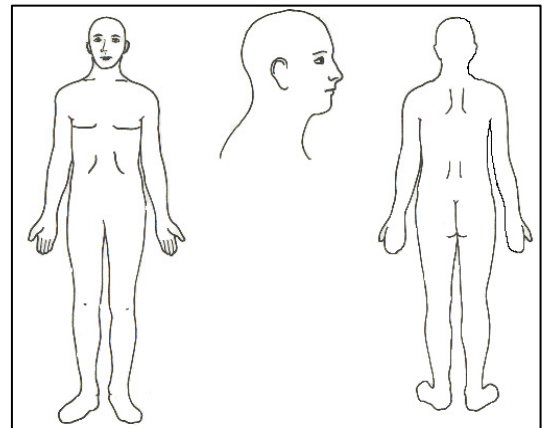
What happened in the above accidents? \_\_\_\_\_

Are there any other current or previous health conditions that may be affecting your health or functioning? Y  N

If yes, Please explain. \_\_\_\_\_

**IMPORTANT:** Please indicate, if you have any of the following conditions, because, if so, standard massage techniques might not be appropriate.

- High Blood Pressure
- Swelling/Edema
- Recent Injury
- Fever / Acute Infection
- Undiagnosed Acute Pain
- Nervous system disorders
- Gastrointestinal disorders
- HIV/AIDS/ Hepatitis/ Infectious disease
- Disease of the heart or blood vessels
- Osteoporosis
- Diabetes
- Chronic Pain Treatment
- Cancer
- Stroke
- Kidney disease
- Liver disease



**Mark Areas: X = pain O = tight**

I understand that the Massage Therapist does not diagnosis, prescribe or treat any specific condition nor is Massage Therapy a substitute for examination, diagnosis and treatment by a physician. I consent to receive massage from the clinic and will inform the Massage Therapist at each visit of any changes in my health.

I authorize the release of any medical information necessary to process my claims and I authorize payment of medical benefits to *The* Mantonya Chiropractic Centers.

\_\_\_\_\_ I understand that I must give a 24 hour cancellation notice or my account will be charged \$15.

Signature \_\_\_\_\_ E-mail \_\_\_\_\_ Date \_\_\_\_\_