CORNERstone
CHIROPRACTIC OF ANTIGO

2006 Progress Boulevard Antigo, WI 54409 715.623.5481

MASSAGE THERAPY – WE'RE GLAD YOU ARE HERE

Name: _____ Age: _____ Today's Date: _____

Address: _____City: _____ St: ____ Zip: _____

Phone (home): _____ (cell)_____ Preferred Contact: Home / Cell / Either

SSN#:_____ Birth date: _____/_____/_____ Number of children _____

E-Mail: _____ I Am: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Widow

Occupation/Employer/School: _____

Emergency Contact/Relationship: _____Phone: _____

How did you hear about us? ☐ Location ☐ Doctor ☐ Internet ☐ Ins Co Referral ☐ Friend or Family Member

Who can we thank for referring you? _____

We promise to treat you with respect, compassion, and understanding.

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Reason for today's visit? _____

Other Doctors seen for this condition (please list):

□ Chiropractor _____ □ Medical Doctor _____

□ Other / Alternative Care _____

Are you currently/regularly seeing ANY healthcare practitioner? Please check (√) ☐ Yes ☐ No

If yes, why? _____

Have you experienced a professional massage? Please check (√) ☐ Yes ☐ No If you checked yes, Why?

_____

If you checked yes above, have you experienced any allergic reactions to massage oils, lotions, gels, scents, ointments or any other substance that had been used during the massage? (√) ☐ Yes ☐ No

If Yes, What? _____

What are your allergies, if any? _____ ☐ None

Is there a particular area where you feel any pain or discomfort? (√) Yes ☐ No ☐

If Yes, where? _____

Are there any areas in which you prefer <u>NOT</u> to be massaged? Please check (√) ☐ Yes ☐ No

If yes, check (√) ☐ Back ☐ Feet ☐ Neck ☐ Front of legs ☐ Back of legs
☐ Hands ☐ Arms ☐ Gluteus ☐ Head ☐ Abdominal

If any, what are your goals during this massage session? _____

MASSAGE SAFETY TO ENSURE SATISFACTION

Have you consumed any alcohol within the last 24 hours? (√) ☐ Yes Amount: _____ ☐ No

Please list & explain any medications that you are taking or have just finished. (over-the-counter, vitamins, herbals, prescribed, pain relievers, etc.)_____

Please list and describe **ALL** injuries, pains, ailments, accidents, surgeries, and illnesses that you have experienced: _____

HEALTH HISTORY

Please check (√) any that apply to you (this includes any discomfort, pain or injury).

Musculo-Skeletal

☐Headaches/Pain
☐Neck/Jaw
☐Shoulder/Arm
☐Chest/Abdominal
☐Hip/Leg

☐Ankle/Feet
☐Any Back Area
☐Tendonitis/Bursitis
☐Other: _____

☐Bone/Joint disease
☐Broken/Fractured Bones
☐Pins/Plates
☐Spasms/Cramps
☐Sprains/Strains

☐Arthritis
☐Lupus/TMJ

Skin

☐Rashes
☐Athlete's Foot
☐Warts
☐Allergies
☐Other: _____

Digestive

☐Constipation
☐Gas/Bloating
☐Diverticulitis
☐Irritable bowel
☐Problem Urinating

Reproductive

☐ PMS
☐ Menopause
☐ Other _____

☐ Pregnant
Stage_____

Nervous System

☐Herpes/Shingles
☐Numbness
☐Persistent Pain
☐Sleep Disorders
☐Consciousness Levels (Seizures/Fainting)

Circulatory System

☐Heart Problems
☐Varicose Veins
☐Blood Clots
☐Blood Pressure
High ____ Low _____

☐Lymphedema
☐Allergies (specify below)

☐ Sinus Problems
☐ Difficulty Breathing

☐Other: _____

Please briefly explain ANY condition checked above: _____

PLEASE INITIAL EACH STATEMENT & SIGN BELOW

___ I have stated all medical conditions that I am aware of and will update the massage therapist with any changes to my health.

___ I understand that the massage therapist will not diagnosis any medical condition and will not prescribe any medications. I understand massage is not a substitute for visiting a health care provider.

___ I understand that the practice of massage is for relaxation and/or the relief of body tension. I chose to receive this massage. I understand it is my obligation to inform the practitioner if I experience any pain or discomfort.

___ By initiating here you understand payment is due before/after your massage.

_____ CLIENT SIGNATURE AND DATE

_____ PRACTITIONER SIGNATURE AND DATE

_____ CLIENT UNDER THE AGE OF 18: PARENT/GUARDIAN SIGNATURE