



Phone (509) 965-9820
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www.Active-Life-Chiropractic.com

Massage Registration and History

Name: _____ Today's Date: _____
 First Middle Last

Address: _____
 Street Apt# City State Zip

Cell phone: (____) _____ Home phone: (____) _____ Email: _____

Date of Birth: _____ Gender: _____ Marital Status: _____ SS #: _____

Employer/Occupation: _____ Phone: (____) _____

Employer Address: _____
 Street City State Zip

Emergency Contact/Relationship: _____ Phone: (____) _____

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Body region 1 (Most painful/problematic)

Please indicate in which region of the body you are having symptoms _____
Note any symptoms other than pain you notice in this region _____
Is there any pain radiating from this area and/or any numbness, tingling or weakness _____

On a 0-10 scale with 0 being no pain at all and 10 being the worst imaginable pain please rate the following for this area: Average pain intensity ____/10 Current pain intensity ____/10 Worst pain intensity ____/10

How often do you feel these symptoms _____ How long do these symptoms last with each episode: _____ What % of time you are having pain in this region _____%

If pain is intermittent, explain when and/or what brings it on? _____

When did this initially start _____ Was it gradual or sudden _____ How did it happen _____

Nature of Injury ___Auto ___Work ___Accident ___Illness ___Pain Management ___Other

Have you had this before _____ Any imaging of this area/from when _____

When/Was it treated/By whom/Was it helpful _____

Any treatment for this occurrence _____

<p style="text-align: center;">Massage Information:</p> <p>How did you hear about us? _____</p> <p>Have you ever received a professional massage before? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, How often do you receive massage? _____</p> <p>Do you have a preferred style? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">Medical History:</p> <p>Do you suffer from chronic or persistent pain/discomfort? _____</p> <p>If so, For how long? _____</p> <p>Do you know what caused it or when the symptoms seem to get worse or better? _____</p>
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Do you prefer your massages to be relatively silent or would you prefer your therapist to converse with you? _____

Specify: Light pressure Medium Pressure
 Deep pressure

What type of massage are you seeking today?

Relaxation Deep pressure/ Therapeutic
 Pregnancy Thai Yoga

Are you sensitive to fragrances or perfumes?
 Yes No

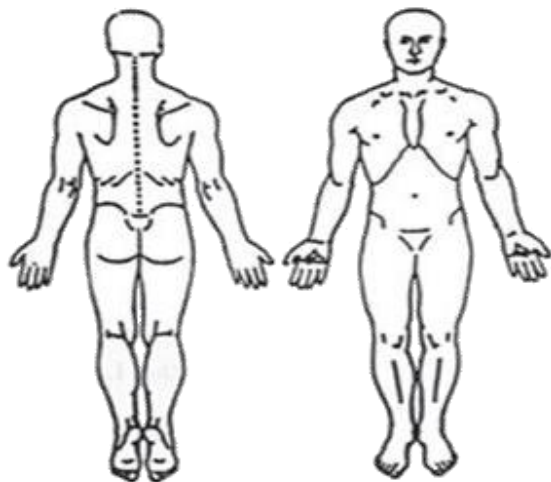
Do you have sensitive Skin? Yes No

Do you exercise regularly? Yes No

If so, What type(s)?

What are your common areas of pain or tension?

Use the highlight tool to indicate areas you would like the massage therapist to focus on during your session:



Do you see a chiropractor? Yes No

If yes, Who is it?

Are you currently under medical care? Yes No

Are you currently taking Prescription medications?
If so, For what?

Please indicate any conditions that you have had or currently have? (Continued on back page)

- | | |
|--|--|
| <input type="checkbox"/> Headaches/
Migraines | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Allergy/Sensitivity | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Arthritis/Tendonitis | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Neck/Back Injuries |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Abnormal Skin
Condition | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Heart/Circulation
Problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Joint
Replacement/Surgery | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> High/Low Blood
Pressure | <input type="checkbox"/> Sprains/Strains |
| | <input type="checkbox"/> Recent Injuries |
| | <input type="checkbox"/> Major Accident |
| | <input type="checkbox"/> Lack of or Reduced
Feeling/Sensation |

Explain any of the conditions you have marked above:

Patient Signature _____ DOB _____ Date _____