ACTIVE LIFE CHIROPRACTIC
a Sports Injury & Family Practice

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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: (____)** _____

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 worse 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 _____

Massage Information:	Medical History:
How did you hear about us? _____ Have you ever received a professional massage before? ☐ Yes ☐ No If yes, How often do you receive massage? _____ Do you have a preferred style? ☐ Yes ☐ No	Do you suffer from chronic or persistent pain/discomfort? _____ If so, For how long? _____ Do you know what caused it or when the symptoms seem to get worse or better? _____

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

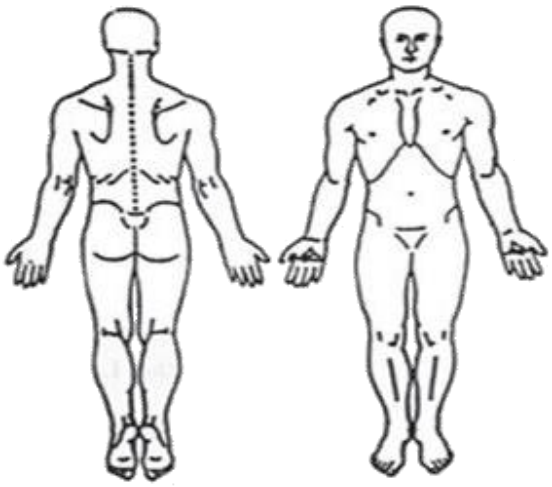
Do you exercise regularly? ☐ Yes ☐ No

If so, What type(s)?

_____

What are your common areas of pain or tension?

Circle any 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)

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

Explain any of the conditions you have marked above:

Patient Name _____ DOB _____