



# Zygmont Family Chiropractic

## Massage Client Medical History & Health Information

Today's Date: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Hm Ph: \_\_\_\_\_  
 City/State: \_\_\_\_\_ Zip \_\_\_\_\_  
 Wk Ph: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Cel Ph: \_\_\_\_\_

### Zygmont Family Chiropractic

Have you had massage before? Y \_\_\_ N \_\_\_

Email Address: \_\_\_\_\_

How did you hear about Zygmont Family Chiropractic?

General Medical Information Please circle all that apply, if necessary explain below.

Do you frequently experience: .stress . headaches .back or neck pain?

In the last 2 years have you had: .surgery . broken bones . cardiac/ circulatory problems?

Do you have: . tension or soreness in a specific area? ( specify if yes)

\_\_\_\_\_ .numbness or stabbing pains? (specify if yes)

\_\_\_\_\_ . sensitivity to touch/pressure in any area? ( specify if yes)

If you are experiencing pain please specify level on scale:

Mild 1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Severe

Is there anything that makes your condition worse?

\_\_\_\_\_ Please circle all that apply:

.Allergies (specifically topical) .Diabetes

.High blood pressure .Epilepsy

.Pregnant .Wear contacts?

.

**Do you have any other medical condition we should be aware of? (specify)  
Comments (use back if necessary):**

**Please take a moment to carefully read the following information and sign where indicated.**

**I understand massage I receive is for relaxation, relief of muscular tension or pain, and improving circulation.**

**If I experience discomfort I will inform the practitioner. I understand massage therapy is not a substitute for medical examination or treatment, that massage therapists do not diagnose, prescribe or treat any illness, and that nothing in the course of the session(s) given should be construed as such.**

**I have stated all medical conditions. I will notify the practitioner of any changes in my medical profile, and agree that there shall be no liability on the practitioner's part should I fail to do so.**

**I agree to pay for all scheduled appointments that I am unable to keep unless I notify the therapist at least 24 hours in advance. I understand that if I arrive late for an appointment I am expected to pay for the full session and any extension beyond the originally scheduled ending time will be at the therapist's discretion.**

**Signed: \_\_\_\_\_ Date:**

\_\_\_\_\_