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Point Family
Wellness and Chiropractic

Welcome to Point Family Wellness and Chiropractic!

Client General Information

(Please Print in Black or Blue Ink) Today's Date:____/____/____

Name: (First, Last)____ Date of Birth:____/____/____

Gender: ☐ Male ☐ Female ☐ Other ☐ Not Specified

Address:____ City, State, Zip:____

Phone:____ Email:____

Occupation:____ Referred by (Where did you hear about us?):____

Emergency Contact:____ Phone:____

Massage Information

Have you had a professional massage before: ☐ Yes ☐ No If yes, how recently:____

What type of massage are you seeking: ☐ Relaxation ☐ Therapeutic/Deep Tissue ☐ Other ____

What pressure do you prefer: ☐ Light ☐ Medium ☐ Deep

Do you have any allergies to oils, lotions, ointments: ☐ Yes ☐ No If yes, please explain: ____

____

Are you wearing contact lenses: ☐ Yes ☐ No

What are your goals for this massage session:____

Medical History

Are you currently under medical supervision: ☐ Yes ☐ No If yes, please explain:____

____

Please list any medications or drugs you are currently on: *(Please include prescription and over the counter medications)*

Medication	Reason	Medication	Reason

Do you see a chiropractor: ☐ Yes ☐ No

Are you pregnant: ☐ Yes ☐ No ☐ NA If yes, how far along:____

Do you suffer from chronic pain? ☐ Yes ☐ No If yes, please explain:____

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment? ☐ Yes ☐ No

If yes, please explain:____

Health History - Musculoskeletal

Please indicate if you have any of the following conditions: ☐ Bone or joint disease ☐ Tendonitis/bursitis ☐ Arthritis/Gout

☐ Jaw Pain/TMJ ☐ Lupus ☐ Spinal problems ☐ Migraines/headaches ☐ Osteoporosis

Health History - Respiratory

Please indicate if you have any of the following conditions:

☐ Breathing difficulty/asthma ☐ Emphysema ☐ Sinus problems ☐ Allergies, please list:____

Health History – Nervous System

Please indicate if you have any of the following conditions:

☐ Shingles ☐ Numbness/Tingling ☐ Pinched nerve ☐ Paralysis ☐ Multiple sclerosis ☐ Parkinson's disease ☐ Fibromyalgia

Health History – Circulatory

Please indicate if you have any of the following conditions: ☐ Heart condition ☐ Phlebitis/Varicose veins ☐ Blood clots

☐ High/Low blood pressure ☐ Lymphedema ☐ Thrombosis/Embolism

Health History - Skin

Please indicate if you have soft tissue/joint dysfunction in any of the following areas:

☐ Rashes ☐ Cosmetic surgery ☐ Athletes foot ☐ Herpes/cold sores ☐ Eczema/Psoriasis ☐ Bruise easily

Health History - Digestive

Please indicate if you have a family history of following conditions:

☐ Irritable bowel syndrome ☐ Bladder/Kidney ailment ☐ Colitis ☐ Crohn's disease ☐ Ulcers

Health History – Reproductive

Please indicate if you have any of the following conditions: ☐ Ovarian/ Menstrual problems ☐ Prostate problems

Health History - Psychological

Please indicate if you have a family history of following symptoms or conditions: ☐ Anxiety/Stress ☐ Depression

Health History - Other

Please indicate if you have a family history of following symptoms or conditions:

☐ Cancer/Tumors ☐ Diabetes ☐ Drug use ☐ Alcohol use ☐ Tobacco use

☐ Other medical conditions not listed: _____

Please explain any of the conditions indicated in the health history above:_____

_____

_____

Health Goals

What are your top three health goals:

1._____ 2. _____ 3._____

Do you have any health concerns for other family members today?_____

Are you open to other therapies to help improve your care? ☐ Acupuncture ☐ Chiropractic ☐ Nutrition

Massage Therapy Informed Consent

I understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so pressure may be adjusted to my comfort level. I further understand that massage should not be constructed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be constructed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. (We reserve the right to charge a $30.00 Cancellation Fee for all appointments cancelled or missed without 24 hours advance notice)

Signature

I have read the massage therapy informed consent above and agree to all the policies.

Client Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

Therapist Signature:_____ Date:_____