

Personal Health Information

Personal Data

Name _____ Date _____ Referred by _____

Address _____ Phone – day: _____

City/State/Zip _____ Phone – Eve: _____

Birthday _____ Occupation/Employer _____

Primary Health Care Provider _____ Phone _____

Emergency Contact _____ Phone _____

Massage History/Treatment Information

Have you ever received a professional massage? _____

If yes, frequency _____ Date of last massage _____

What results do you want from your massage session? _____

List stress reduction and exercise activities. Include frequency. _____

List current medications, including aspirin, ibuprofen, etc. _____

Previous History (include year and treatment received)

Surgeries/Accidents: _____

Minser Chiropractic Clinic, 203 Park Ave S, Suite 101, St. Cloud, MN 56301, 320-253-5650

Health History

Musculo-Skeletal

- Bone or joint disease _____
- Tendonitis _____
- Bursitis _____
- Broken/fractured bone _____
- Arthritis _____
- Sprain/strains _____
- Low back, hip, leg pain _____
- Neck, shoulder, arm pain _____
- Headaches/head injuries _____
- Spasms/cramps _____
- Jaw pain/TMJ _____
- Lupus _____
- Other _____

Circulatory

- Heart condition _____
- Varicose veins _____
- Blood clots _____
- High/low blood pressure _____
- Lymph edema _____
- Breathing difficulty _____
- Sinus problems _____
- Other _____

Skin

- Allergies _____
- Rashes _____
- Athletes foot _____
- Warts _____
- Other _____

Digestive

- Constipation _____
- Gas/bloating _____
- Diverticulitis _____
- Irritable bowel syndrome _____
- Other _____

Female

- Pregnant
If yes, how many weeks _____

It is my choice to receive massage therapy. I realize that the treatment is being given for my well being of mind and body. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation. I agree to communicate with my practitioner any time I feel my well being is being compromised.

I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder. Nor do they prescribe medical treatment, pharmaceuticals or perform spinal manipulation. I acknowledge that massage therapy is not a substitute for medical examination or diagnosis.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

Signature _____ Date _____

***Please inform the office if you cannot make a massage appointment at least 24 hours before your scheduled appointment.**