keng chiropractic

Print Name _____

MASSAGE THERAPY

I understand the massage services are designed to be a service and are in no way to take the place of a doctor's care. When information is exchanged during any massage session, it should be educational in nature and is not intended to replace a doctor's order. Any information is to be used at your own discretion. I have read this form and completed it to the best of my knowledge.

Name: _____ Date of birth: _____ Sex: _____

Address: _____ City: _____ Zip: _____

Home phone: _____ Cell: _____ Work: _____

In case of an emergency, notify: _____ Phone: _____

Occupation: _____ Referred by: _____

Have you ever experienced a professional massage/body work session? Yes or No

What do you expect from this massage? _____

Any areas that you specifically like to have worked on? _____

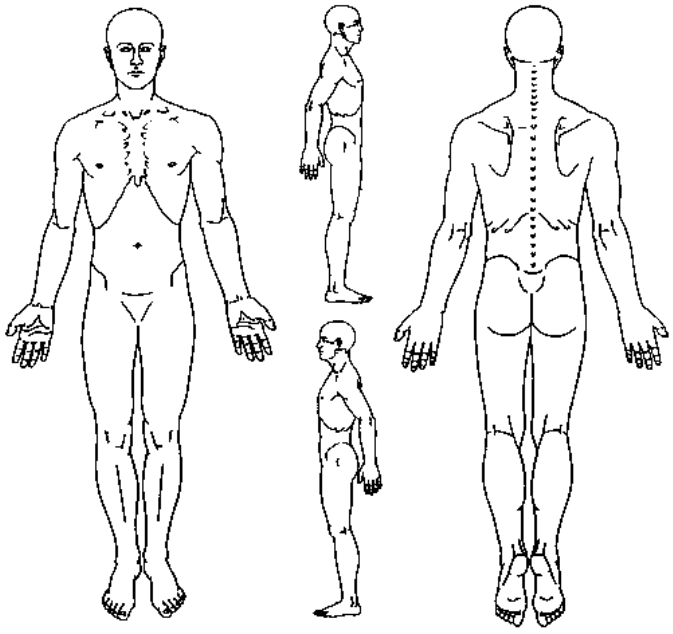
How often do you exercise? _____

How many glasses of water do you drink on a daily basis? _____

Are you pregnant? _____

GENERAL MEDICAL INFORMATION

Please mark your area of your concern on the diagram below.



How did this condition develop? _____

_____

When was the very first time you noticed this problem? _____

_____

Have you ever received treatment for this condition? _____

_____

Is there anything that makes your problem worse? _____

_____

Do you have a problem lying on your stomach or back for an extended period of time? _____

_____

Please check any illnesses that may apply:

O Painful Joints	O Arthritis	O Liver	O Stroke	O Varicose Veins
O Cholesterol Prob.	O Diabetes	O Seizures	O Headaches	O Bruising
O High Bl Pressure	O Cancer	O Phlebitis	O Thyroid	O Skin Disorder
O Lung Disease	O Numbness	O Scoliosis	O Osteoporosis	O Asthma
O Sensitive Skin	O Bulging Disc	O Back Surgery	O Neck Surgery	

Signature _____ Date _____