Caledonia Chiropractic Clinic

5401 Douglas Ave., Suite A,
Racine, WI 53402
Phone: 262.681.8829

MASSAGE CLIENT FORM

Full Name: _____ Date: _____

Address: _____ Apt#: _____

City: _____State _____ Zip Code: _____

Date of Birth: _____Email Address: _____

Home Phone: _____ Business/Cell Phone: _____

Whom may we thank for referring you?_____

Do you prefer to receive calls at: ☐Home ☐Work ☐Cell ☐Any

Person to contact in case of emergency: _____Phone: _____

Primary Care Physician: _____ Phone: _____

Occupation: _____

Have you ever experienced a professional massage before: ☐Yes ☐No

Are you here for: ☐Relaxation Massage ☐Therapeutic Massage

Are You Pregnant: ☐No/NA ☐Yes my due date is: _____

Medications: _____

Hospitalization: _____When: _____

Hospitalization: _____When: _____

Injuries/Accidents that are still affecting you:

_____

_____

_____

_____

Appliances (Screws, pacemakers, etc): _____

Broken Bones: _____When: _____

Please list any spine or back injuries, including any disc problems such as bulging, rupture, herniated, and the location. Also any treatments you are currently undergoing:

_____

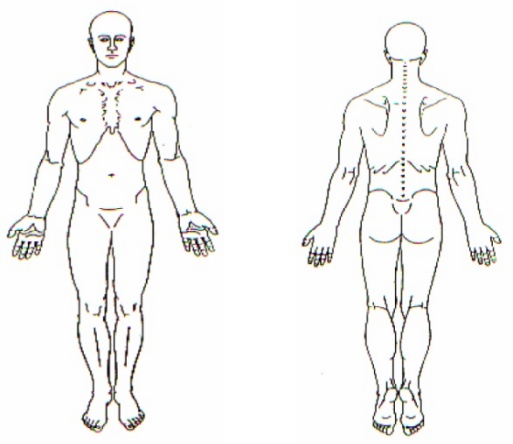
_____

_____

For the following conditions, please place a √ in the past column if you have had the condition in the past. If you currently have a condition, please place a √ in the present column:

Past	Present		Past	Present	
☐	☐	Headache/Migraines	☐	☐	Bone or Joint Disease
☐	☐	Neck/Shoulder pain	☐	☐	Arthritis, Bursitis, or Gout
☐	☐	Upper back pain	☐	☐	Osteoporosis
☐	☐	Mid back pain	☐	☐	Fibromyalgia
☐	☐	Low back pain	☐	☐	Varicose veins
☐	☐	Wrist pain	☐	☐	Heart condition
☐	☐	Hand pain	☐	☐	Respiratory condition
☐	☐	Digestive disorder	☐	☐	Anxiety or stress
☐	☐	Hip/leg pain	☐	☐	Blood clots
☐	☐	Ankle/foot pain	☐	☐	Diabetes
☐	☐	Sprains	☐	☐	High blood pressure
☐	☐	HIV/AIDS	☐	☐	Cancer
☐	☐	Hepatitis Type:			

Please indicate with an **X** on the drawing below the areas where you are feeling discomfort:



I understand that massage is not a replacement for medical care and that no diagnosis will be made. I will keep my therapist informed of any medical conditions to make sure there are no contraindications for massage. I know if I fail to do so, my therapist is not liable for any problems arising from my massage. I also understand that any illicit or sexual suggested remarks made by myself will result in termination of my session and any further therapy.

Missed Appointment Policy:

24 HOUR NOTICE is required for the cancellation or rescheduling of an appointment. If you cannot keep your appointment and have not given 24 hour notice, a fee for the full amount of the appointment will be billed to you. If you are using a Gift Certificate and you miss a scheduled appointment or make a cancellation without 24 hour notice, the certificate will be void.

Signature: _____ Date: _____

Gratuity is not included