Access to Health Chiropractic Center
Massage Therapy Registration

Date: _____

How were you referred to our office? _____

Name: _____

Address: _____

Date of Birth: ___/___/____ Age: _____

Home Phone: _____ Other contact number:_____

Emergency Number:_____ Relation:_____

Health Conditions and Medications:_____
_____
_____

Do you have any skin allergies or sensitivity?
_____

Have you been injured in a motor vehicle or other incident recently?
____Yes ____No If yes, how long ago? _____

Are you treating with a doctor? _____

Have you had any surgery? _____

Are you pregnant or have any indication that you may be pregnant? _____If yes, how many months?_____

What is the reason for your visit today? Relaxation Stress Reduction
Pain Relief

What would you like to get out of your session? _____
_____

Have you ever had a professional massage? _____
_____

Main areas of concentration: Neck Shoulders Arms
Upper Back Mid Back Low Back Legs Feet

Family Medical History:

Please indicate if any of your family members have been diagnosed with any of the following:

	Mother	Father	Grandparents	Siblings
Heart Disease	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Digestive Disorders	_____	_____	_____	_____

Personal Health History:

Have you in the past or are you presently experiencing difficulty with any of the following:

Anemia _____
Arthritis _____
Asthma _____
Bones-Osteoporosis ____
Cancer _____
Diabetes _____
Digestive Disorder _____
Dizziness _____
Eczema _____
Excessive Urination _____
Headaches _____
Heart Disease _____
High Blood Pressure _____
HIV _____
Nervousness _____
Neuritis _____
Rheumatic Fever _____
Sinus Trouble _____
Skin Allergies _____
Tuberculosis _____
Other _____
_____