HOLLY SPRINGS
CHIROPRACTIC & MASSAGE

Pro Balance
MASSAGE

Massage Patient History & Financial Policy

If this is your first massage at Holly Springs Chiropractic & Massage, please fill out this form completely.

Name:_____ Cell #:_____

Address:_____ Home #:_____

City:_____ State & Zip:_____ DOB:_____

Occupation:_____ Email:_____

Emergency Contact Name:_____ Phone: _____

Whom may we thank for referring you?_____

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

Date of Initial Visit_____

Have you ever had a professional massage before? Yes No
If yes, how often did you receive massage therapy?_____

Do you have any difficulty lying on the front, back, side? Yes No
If yes, explain:_____

Do you have any allergies to oils, lotions, or ointments? Yes No
If yes, explain:_____

Do you have sensitive skin? Yes No
Are you wearing: Contact lenses ( ) Dentures ( ) Hearing aids ( )

Do you sit for longs hours at a workstation, computer or driving? Yes No
If yes, explain:_____

Do you perform any repetitive movement in your work, sports or hobby? Yes No
If yes, explain:_____

Do you experience stress in your work, family, or other aspect of your life? Yes No
If yes, how do you think it has affected your health?
Muscle tension ( ) Anxiety ( ) Insomnia ( ) Irritability ( ) Other:_____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
If yes, please identify:_____

Do you have any particular goals in mind for this massage session? Yes No
If yes, explain:_____

Medical History:

In order to plan a massage session that is safe and effective, I will need some general information about your medical history.

Are you currently under medical supervision? Yes No
If yes, explain:_____
Do you see a Chiropractor? Yes No
If yes, how often:_____
Are you currently taking any medications? Yes No
If yes, please list:_____

Please check any condition listed below that applies to you:

( ) contagious skin conditions
( ) open sore or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprain/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivities
( ) heart conditions
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/ blood clots
( ) joint disorder/ rheumatoid arthritis/osteoarthritis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensations
( ) back/neck problems
( ) fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy (If yes, how far along?_____)

Please explain any condition that you have marked above:_____

_____

_____

Is there anything else about your medical history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?_____

_____

Draping will be used during this session – only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian of any client under the age of 17.
I, _____(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/ or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed 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 construed as such. Because massage should 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 the 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.

Financial Policy: I understand that a fee of $25 will be charged if I "NO SHOW" for and appointment. If I am late for an appointment, my session will be shortened, but I will still be responsible for the full time that I was scheduled for. I will call in a timely manner if I cannot keep my appointment. I may request a superbill to submit to my insurance. Payment is due at the time of services are rendered. We accept cash, check, and all major credit cards.

Signature of Client:_____ **Date:**_____