NSM#

Client History Form

First Name only _____ Have you had a massage before?_____

Nationality _____ Marital Status _____

What are your major complaints?_____
_____

Please list all areas of discomfort or limitations_____
_____
_____

Have you ever been to a chiropractor? _____ If so, who and for?_____
_____

Have you had any recent injuries? _____If so, explain._____
_____

Have you had any surgery? _____ If so, explain_____
_____

Have you had any whiplash?_____ If so, explain_____

Have you received any radiation or chemo therapy?_____ If so, when and list type of cancer.(Please talk over with the therapist about this topic)_____
_____
_____

Do you have any medical conditions (both minor and major) that I should be aware of? Explain
_____
_____

Are you currently taking any medication?_____ If so, list each item and reason_____
_____
Do you take any drugs by injection? _____List drug(s) and where_____
_____
Are you at risk for blood clots? _____Are you currently taking blood thinners?_____
_____
Do you have high blood pressure? _____Are you being treated?_____
Are you pregnant?_____
Are you wearing contact lenses?_____
Are you wearing dentures, partials or hearing aid?_____

Do you have any skin allergies, or sensitivities?_____ If so, explain._____

_____