# Mission Chiropractic & Wellness

913.432.4780

***You are about to experience the many benefits of a therapeutic massage. To assist us in providing you with the best possible massage experience please take a few minutes to complete the following questions. The information you provide is strictly confidential and will only be used to tailor your massage to your individual needs. Please feel free to ask any questions that you might have. Then just sit back, relax and let us do all the work.***

Name: ______________________________________ Today's Date:________________

Address:______________________________ City:________________ State:___ Zip:________

Daytime phone:____________ Evening phone:____________ E-Mail_________________

Date of birth:______________ Occupation/Location_____________________________

**How did you hear about us?** _________________________________

## BODYWORK HISTORY

Have you received a professional massage in the past? YES:____ NO:____

*If YES, how often?_______ Where:_____________________ Last time received ?___________*

Are you currently under a physician and/or chiropractor's care? YES:_____ NO:____

*If YES, Name(s):__________________________________________ Phone #(s):______________*

Do you currently take any medications? YES:____ NO:____

*If YES, please list medications:* __________________________________________

Please list any injuries or surgeries you have had and indicate the year:_____________________________
_________________________________________________________________________________

***In case of an emergency contact:______________________ Phone #(s):______________**

## Please indicate if you have a history of any of the following:

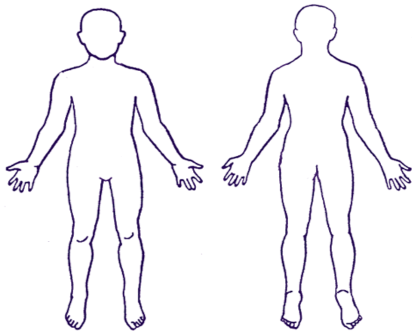
High/Low blood pressure; YES:___ NO:___
Circulatory Problems: YES:___ NO:___
Open cuts: YES:___ NO:___ Where?_____
Osteoporosis: YES:____NO:______

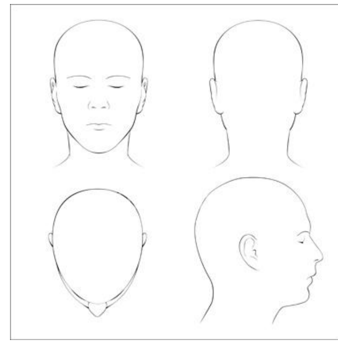
Heart disease: YES:___ NO:___
Diabetes: YES:___ NO:___
Allergies: YES:____ NO:_____
Bruise easily: YES:_____NO:_____

Tumor or cancer: Skin disorder (eczema): YES:___ NO:___
Are you being treated for depression/anxiety? YES:____NO: ____
Are you pregnant? YES: _____NO:____
* Other Serious/chronic illness (contagious symptoms)____________________________

**TURN OVER**

**Please mark any current problem areas below: (pain, tension, stiffness, limited movement)**





COMMENTS:___________________________________________________________________________

I have provided the above information to the best of my knowledge. I understand that therapeutic massage services are designed to be a health aid and are in no way a replacement for a medical health practitioner's care. Information exchanged with therapist is educational and intended to help me become more familiar with my personal health status, and is to be used at my own discretion. If I feel any discomfort during my sessions I will notify therapist immediately. Any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I will honor my appointments and I agree to cancel 24 hours in advance. I agree to pay the full fee for any appointment missed without 24hours notice.

SIGNATURE:______________________________ DATE:_________________________________

**FOR OFFICE USE ONLY**

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