



ARVIDSON CHIROPRACTIC CENTER

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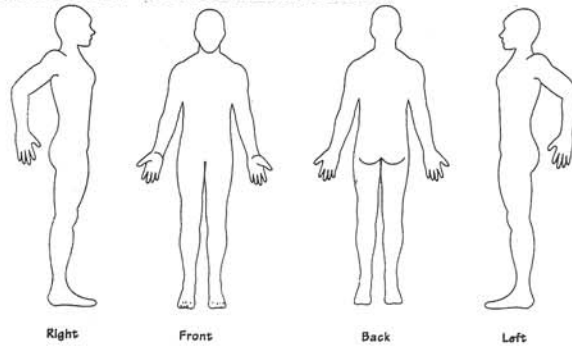
MASSAGE HEALTH HISTORY

Why are you seeking massage treatments? Relaxation Pain Relief Stress Reduction Other _____

Have you ever had a massage or bodywork treatment before? Yes No

If in pain, tense, or sore where are your areas of discomfort? Please Mark Below

Other areas of pain or concern?



When did you first notice the complaint? _____

Has this occurred before? _____

What brought it on? _____

What aggravates the condition? _____

What do you believe the problem is? _____

Has there been a medical diagnosis? _____

By Whom _____ When? _____

Are you

- Right handed Left handed
- Taking medication _____
- Taking supplements / vitamins _____
- Pregnant Due Date: _____
- Wearing Contact Lenses _____
- Diabetic _____

Have you ever had

- Surgery _____
- Allergies _____
- Accidents _____
- Broken Bones _____
- Skin Problems _____
- High Blood Pressure _____
- Cardiovascular Problems _____

Any other Medical condition or Physical limitation the therapist should be aware of before treatment

It is my choice to receive massage therapy. I realize that the treatment is being provided for the well being of my mind and body. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I understand that massage practitioners DO NOT diagnose illness, disease, or any physical or mental disorders; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I am aware of the fee structure and agree to pay for all services at the time they are rendered, unless prior arrangements have been made.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

Signature: _____ Date: _____