Dr. T.J. McKay, D.C.Dr. K.B. Jenkins, D.C.
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Massage Therapy Client History

All information disclosed is confidential and will be used for no other purpose than to provide the massage therapist with a better understanding of the client's picture.

Name: _____ Date: _____

Address: _____ Res. #: _____

_____ Postal Code: _____ Bus. #: _____

Weight: _____ Height: _____ D.O.B. _____ Gender: _____

Occupation: _____ Family Physician: _____

Exercise / Sports Activities: _____

Hobbies / Recreational Activities: _____

How did you find out about the massage therapist / clinic? _____

Medication: _____ Condition: _____

_____ _____

Surgeries, past injuries, motor vehicle accidents?

Type: _____ Date: _____ Treatment: _____

_____ _____ _____

Please check any condition you presently experience or have experienced in the past:

- ❑ Allergies/sensitivities
- ❑ Ankle/foot pain
- ❑ Arthritis
- ❑ Arm Pain
- ❑ Asthma
- ❑ Back Pain
- ❑ Bone Infection
- ❑ Calcium dep./bone chips
- ❑ Cancer/tumors
- ❑ Carpal tunnel syndrome
- ❑ Cold intolerance
- ❑ Depression/anxiety
- ❑ Diabetes
- ❑ Diet/nutritional concerns
- ❑ Digestive disorders
- ❑ Dizziness
- ❑ Elbow pain
- ❑ Epilepsy
- ❑ Fainting
- ❑ Fatigue
- ❑ Fibromyalgia
- ❑ Fluid retention
- ❑ Fractures
- ❑ Hand pain
- ❑ Headaches
- ❑ Hemophilia
- ❑ Hernia
- ❑ Herniated disk
- ❑ Hi/lo blood pressure
- ❑ Hip/buttock pain
- ❑ Hormone deficiencies
- ❑ Infectious disease
- ❑ Insomnia
- ❑ Jaw Pain
- ❑ Kidney/bladder disorder
- ❑ Knee pain
- ❑ Lower leg/calf pain
  - • during activity ___
  - • at rest ____
- ❑ Menopause
- ❑ Multiple sclerosis
- ❑ Muscle spasms/cramps
- ❑ Muscular dystrophy
- ❑ Nausea
- ❑ Nerve damage
- ❑ Neuritis
- ❑ Numbness/tingling
- ❑ Osteoporosis
- ❑ Paralysis
- ❑ Pregnancy
- ❑ Pulled/strained muscles
- ❑ Scoliosis
- ❑ Shin splints
- ❑ Shoulder pain
- ❑ Skin conditions
- ❑ Sprain(s)
- ❑ Stroke
- ❑ Torn ligaments
- ❑ Upper leg pain
- ❑ Varicose veins
- ❑ Whiplash
- ❑ Wrist pain

Please explain any other condition not listed above: _____

_____

SENSORY AIDS, PROSTHESIS, ORTHOTICS?

- ❑ Dentures
- ❑ Pins / Plates
- ❑ Heel Lifts
- ❑ Other _____
- ❑ Artificial Limbs / Joints
- ❑ Splints / Brace

PRESENT SYMPTOMS: What is your major complaint? _____

_____

MINOR COMPLAINTS: Other areas of concern. _____

_____

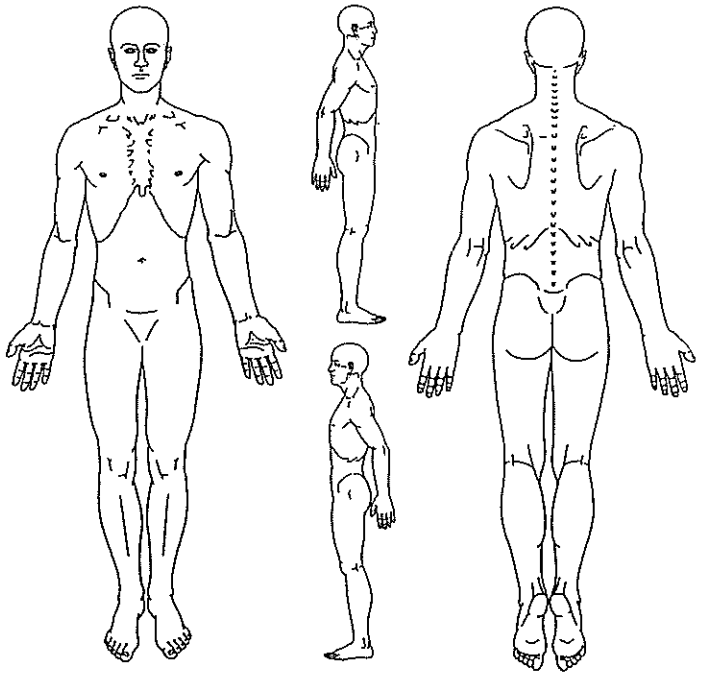
What aggravates your symptoms? _____

_____

What relieves your symptoms? _____

_____

Indicate areas of pain, tingling and numbness.



I understand that massage therapy is an asset to my health, but does not take place of any medical care my physician may recommend. I have given the correct information regarding my health and am not aware of any reasons for not having massage therapy.

Client's Signature: _____ Date: _____

MASSAGE THERAPY
CANCELLATION POLICY

A cancellation of scheduled appointments is required and enforced in our clinic. A patient is required to give **TWENTY-FOUR HOURS NOTICE** to cancel or change an appointment time. Without the 24-hour notice, the full cost of Massage Therapy treatment will be charged to you.

I hereby authorize and grant permission to the Massage Therapist in charge of my treatment and the clinic to employ such policy.

_____ I understand that a **"no show"** appointment will result in the **PATIENT** being charged for the cost of the Massage Therapy treatment, and that these appointments will **NOT** be covered by personal insurance.

DATE: _____ Patient Name (printed): _____

Patient Signature: _____