MASSAGE CASE HISTORY

Terrigal Chiropractic & Natural Therapies Centre

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Phone: (H) _____ (W) _____ (M) _____

Email: _____

Emergency Contact Name: _____ Ph. _____

Occupation: _____

Sports/Activities: _____

Reason for visit: _____

Have you had massage before: Yes/No

Medical History

Muscular/Skeletal System: (spinal disorders, bone fractures, dislocations, muscular pain) Yes/No

_____

Recent Surgery/Hospitalisation/Motor vehicle accidents/Falls: Yes/No _____

_____

Respiratory Conditions: (asthma) Yes/No _____

Skin Conditions: (psoriasis,eczema) Yes/No _____

Nervous System: (epilepsy) Yes/No _____

Headaches: (hormonal, stress, muscular) Yes/No _____

Ongoing/current emotional concerns: (anxiety, ongoing stress, tiredness) Yes/No _____

_____

Sleep Problems: (trouble falling asleep, mind racing, waking in the middle of the night) Yes/No

_____

Endocrine/Immune/Lymphatic conditions: (hormonal imbalance, diabetes, glands) Yes/No

_____

Allergies: Yes/No _____

Pregnant or trying to fall pregnant: (if so how many weeks) Yes/No _____

Medications/herbal remedies: Yes/No _____

_____

Having other treatments: (if so, how effective) Yes/No _____

Water Intake per day: _____

Comments: _____

_____

_____

We appreciate referrals. How did you find out about our clinic? _____

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www.terrigalchiropractic.com.au