Northcote Chiropractic Clinic

MASSAGE FORM

Date:

Name _____ Occupation _____

Address _____

Town _____ Postcode _____

Phone Number (Home) _____ (Mobile) _____ (Work) _____

Date of Birth_____Age _____ ☐ Male ☐ Female (please tick) Marital Status ☐ S ☐ M ☐ P ☐ D ☐ W (please tick)

Email Address _____

Emergency Contact Name _____ Emergency Contact Number_____

Children (Names and ages) _____

Whom may we thank for referring you to our office? /or/ How did you choose us?

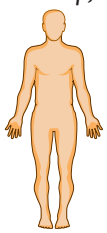
Family / Friend (Name)_____

(Please tick) ☐ Website ☐ Facebook ☐ Workshop ☐ Health Practitioner ☐ Walk-in ☐ Print Advertisement ☐ Other _____

HEALTH CONCERNS – FILL IN ALL AREAS *Please Tick* (√) all that you have experienced in the last 3 months:

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ **Back pain** *(tick area)*
  - ☐ Upper ☐ Mid ☐ Low
- ☐ Balance/Coordination
- ☐ Bladder
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Chronic Fatigue
- ☐ Colds
- ☐ Congestion
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Ear Infections/Aches
- ☐ Epilepsy/Seizure
- ☐ Food Allergies
- ☐ Gallbladder issues
- ☐ G.I. Issues
- ☐ Hand/Wrist Pain
- ☐ **Headaches**
- ☐ Heart Disease
- ☐ Hernias
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ Irregular Cycles
- ☐ Kidney issues
- ☐ Knee/Ankle/Foot Pain
- ☐ **Migraines**
- ☐ **Neck/Shoulder Pain**
- ☐ Pneumonia/Bronchitis
- ☐ Poor Circulation
- ☐ Prostate issues
- ☐ Reflux
- ☐ Reproductive issues
- ☐ Sensory Processing / Spectrum disorder
- ☐ Skin issues
- ☐ Sleep issues
- ☐ Speech problems
- ☐ Thyroid issues
- ☐ Tinnitus/Ringing Ears
- ☐ Vertigo
- ☐ Other

Where is the problem? Please circle or draw on the illustrations and explain or describe your present condition in the lines below *(i.e. sharp, dull, burning, tight, throbbing)*

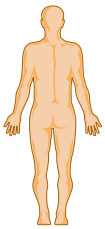


Front

_____

_____

_____



Back

_____

_____

_____

Are you taking any prescription medication? ☐No. ☐Yes. If yes, please list:_____

_____

Are you taking other Medication/Supplements? ☐No. ☐Yes.

Have you had any accidents or been in hospital? ☐No. ☐Yes. Please List. _____

_____

How would you rate your stress level? ☐Low. ☐Mod. ☐High

Is there anything else you would like to ask or inform us of?_____

Have you had a massage before? ☐No. ☐Yes.

Please tick preferred massage technique and main goal: ☐Swedish massage ☐Sports massage ☐Aromatherapy massage ☐Relaxation, Stress Reduction ☐Relieve muscle tension of areas circled on the above diagram.

I, _____*(print name)* I have answered the above question to the best of my ability, I understand that the massage therapy doesn't include medical diagnosis. I give my consent to undergo a massage session. I also understand that I may be contacted by Northcote Chiropractic Clinic with information on other services that may be of benefit to me.

** *Please note our Doctors of Chiropractic can give a medical diagnosis, please ask at reception if you would like to see one of our Chiropractors.*

Signature_____ Date _____

Patient Signature (Legal Guardian)