

BEND WHOLE HEALTH
Family Chiropractic
Bend Massage Center

Client Questionnaire

Date: _____

Referred by: _____

Name: _____

Address: _____

Phone Number: _____ Email: _____

Date of birth: _____

What brings you here today? _____

Is there any area where you would like extra time spent?

Is there any area where you have muscle pain/stiffness/tension (neck, low back, Shoulder, other)? _____

What is your previous experience with professional massage? _____

Daily Activities/sports/hobbies: _____

Habits: _____

Medical History – Please indicate below any significant medical problems, as such conditions can influence the type and/or depth of work done in any given area.

Thank you.

_____ Allergies

_____ Skin condition (acne, rash, allergies, skin cancer, other)

_____ Lymphatic condition (swollen glands, lymphoma, other)

_____ Recent injury or accident (whiplash, sprain, deep bruise, other)

_____ Circulatory condition (heart disease, varicose veins, phlebitis, arrhythmia, other)

_____ Neurological condition (sciatica, numbness/tingling of any area of skin, stroke epilepsy, other)

_____ Joint problems, pain, or stiffness (osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, sacroiliac problems, other)

_____ Bone conditions (osteoporosis, previous fracture, cancer, other)

_____ Headaches (migraines, PMS, tension, cluster, other)

_____ Emotional difficulties (depression, anxiety, other)

_____ Stress

_____ Previous surgery, please state type and date: _____

_____ Are you pregnant?

Can you lie comfortably on your stomach? _____ back? _____

Do you have any body piercings that would be affected by heat etc.? _____

Name of Health Care Provider: _____

Phone number: _____

Insurance Co.: _____ (if applicable - please show copy of insurance card)