



NASHUA FAMILY CHIROPRACTIC

29 Riverside Street, Units A and B, Nashua, NH 03062 P: (603) 880-4150 F: (603) 880-6765

Mission: "To raise the vibration of everyone who walks through our door."
Vision: "To revolutionize healthcare in our community."

Massage Health History Form

Today's Date: _____
Name: _____ Date of Birth: _____ Age: _____
Home Phone: _____ Cell Phone: _____ Height: ____' ____" Weight: ____ lbs.
Street Address: _____ City: _____ State: ____ Zip: _____
Marital Status: _____ Number of Children: ____ Who referred you?: _____
Occupation: _____ Employer: _____ Work Phone: _____
Supervisor: _____ Social Security Number: _____
Spouse's Name: _____ Spouse's Employer: _____
Emergency Contact: _____ Relation: _____ Primary Phone: _____

Have you ever had a professional massage? Yes No
What is your current activity level? low medium high
List current medications: _____
List any injuries: _____
List any surgeries: _____
Do you have any allergies? _____

Do any of the following apply to you?

Arthritis Headaches Sciatica Torn Ligament
 Bruise easily Heart Disease Scoliosis Varicose veins
 Cancer Hypertension Skin condition Wear Contacts
 Diabetes Osteoporosis Tendonitis Other _____
 Digestive issues Pregnant Torn muscle _____

Please explain any of the above checked conditions further _____

What is your primary reason for receiving a massage treatment today? _____

I have stated all medical conditions that I am aware of.

Signature _____ Date _____



NASHUA FAMILY CHIROPRACTIC

29 Riverside Street, Units A and B, Nashua, NH 03062

P: (603) 880-4150

F: (603) 880-6765

Mission: *"To raise the vibration of everyone who walks through our door."*

Vision: *"To revolutionize healthcare in our community."*

Massage Therapy Informed Consent

I, _____, (client) understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch.

The general benefits of massage, possible massage contraindications, and the treatment procedure have been explained to me.

I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the treatment can be adjusted. I have reviewed the therapist's policies, and I understand them and agree to abide by them. I acknowledge that with any treatment there can be risks and I assume those risks. I also acknowledge that I will not hold Nashua Family Chiropractic, P.C. liable for any risk associated with massage therapy.

*Your appointment time is reserved for you. If you cannot make your scheduled appointment, this office requests 24 hours notice. **Failure to provide such notice will result in a \$35 Late Cancellation fee. A No Call/No Show will result in full payment due for services missed.***

Client Name

Client Signature

Date