

Dockter • Lutz

Chiropractic

“Helping you achieve a healthier, drug-free lifestyle”

**Print Name**:

***Past Health History – Last 5 Years***

1. Have you had massage therapy treatments before? If so, when?
2. Have you seen a chiropractor before? If so, when?
3. Please check any and all conditions that apply:

|  |  |  |
| --- | --- | --- |
| CARDIOVASCULAR   * Heart Disease (any type) * Blood Pressure Disorder * Blood Vessel Disorder * Bleeding Disorder | NERVOUS SYSTEM   * Brain Disorders * Cerebrovascular Disorder * Spinal Cord Injuries * Peripheral Neuropathies * Shingles | SKELETAL/JOINTS   * Osteoporosis * Vertebral Disc Disorders * Arthritis (Any Type) * Sprains/Strains * Tendonitis/Bursitis |
| MUSCULAR SYSTEM   * Muscle Tension * Spasms/Cramps * Fibromyalgia * Muscular Dystrophy * Muscular Fibrosis | IMMUNE SYSTEM   * Allergies * Infectious Disease * Positive for HIV/AIDs * Lupus (Systemic/Discord) * Scleroderma | SKIN (Integument)   * Bacterial Infections * Viral Infections * Fungal Infections * Open Sores/Wounds * Eczema |
| RESPIRATORY SYS.   * Common Cold * Pneumonia * Bronchial Bronchitis * Chronic Bronchitis * Emphysema | DIGESTIVE SYSTEM   * Peptic Ulcers * Liver Disease * Gall Bladder Disease * Pancreatic Disorders * Intestinal Disorders | URINARY SYSTEM   * Urinary Tract Infections * Kidney Infections * Kidney Stones |
| ENDOCRINE SYSTEM   * Diabetes Mellitus * Hyperthyroidism * Hypothyroidism | REPRODUCTIVE SYS.   * Endometriosis * Menstrual Cramps * Amenorrhea | OTHER |

1. List and explain any and all below. Please include alternative treatments.
   1. Surgery/Operations:

* 1. Cancer:
  2. Are you under a doctor’s care? Y/N
  3. Are you pregnant? Y/N If Yes, How Many Weeks?

***Current Health History***

* + - 1. Please check any and all symptoms that you are currently experiencing:
* Pain
* Fever
* Diarrhea
* Vomiting
* Open Sores
* Chills
* Fainting
* Weakness
* Seizures
* Dizziness
* Tingling
* Nausea
* Swelling
* Chest Tightness
* Breathing Trouble
* Constipation
* Muscle Tension
* Numbness
* Coughing
* Headaches
* Sweating
* Others:

* + - 1. What are your main goals and concerns for your massage today?

***Massage Therapy Cancellation Policy:***

***When scheduling massage therapy, we reserve the entire appointment time specifically or you. Being that these massage appointments last between 30 minutes and 2 hours, they can be very hard to fill should a client not be able to make their appointment on short notice. Our massage therapists are paid based on the number of sessions performed; therefore this causes them to lose out on income. For that reason we require a 24-hour notice should you need to cancel or change your massage therapy appointment.***

**By signing below, you confirm that you understand this policy and will be respectful of the therapists’ schedule. We reserve the right to request payment in full from those massage therapy clients who no-show or cancel with less than 24-hour notice at least three times.**

*I affirm that I have stated all of my known medical conditions. I understand that the massage/bodywork session is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session I will immediately inform the therapist. I further understand that the massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for mental or physical ailments of which I am aware of. I understand I am having this massage at my own risk and hereby release Doctor • Lutz Chiropractic therapists, staff, and/or doctors from any liability.*

Signature: Date: