LIFETIME Spines
Chiropractic & Massage Therapy

Name: _____ Date: _____
Cell Phone: _____ Date of Birth: _____
Address: _____
City/State/Zip: _____
Email Address: _____
Occupation: _____

Primary reason for visit_____
Secondary reason for visit_____

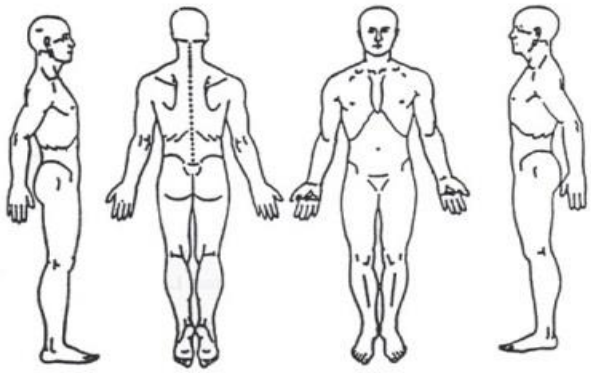
Have you ever had a professional massage before? (Yes) (No) _____
Do you regularly exercise or participate in any sports? (Yes) (No) _____

MEDICAL HISTORY (Circle all that Apply)

Neck Pain	Numbness/Tingling	Headaches/Migraines	Heart Conditions
Mid-back Pain	Arthritis	Dizziness	Blood Clots
Lower Back Pain	Joint disorders	Allergies/Sinus issues	Varicose Veins
Herniated Disc	Osteoporosis	Stress	Breathing difficulty
Sciatica	Osteopenia	Skin Sensitivities	Currently Pregnant? _____

Other Past Medical History: _____
Accidents, Health Issues, Injuries or Past Surgeries: _____
Current Medications: _____
Have you ever been diagnosed with cancer? If so when? _____

Please mark areas of complaint, pain, or tension 0 = FOCUS HERE X= DO NOT TOUCH



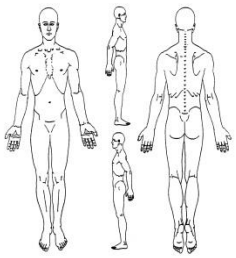
Your Personal Preferences during Massage Treatment - Please don't hesitate to let us know how we can better serve you!

Pressure Preference:	Feather Light	Swedish/Relaxation	Medium/Moderate	Heavy/Firm	Deep Tissue
Talking/Conversation:	None	A little is OK	Talking is fine		

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailments. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that if I need to cancel future massage therapy appointments, I must give a 48 hour notice or I will be responsible for full payment for the therapist time. I hereby give my consent to have bodywork therapy performed on me. Client Signature: _____

For Therapist Use Only

___/___/___ Visit # _____ 30-60-90-120 Time:_____ LMT:_____



Special Requests, Concentration Areas, Changes in Health since last visit or Recent Illness, etc:

_____

_____

_____

Session plan: _____

_____

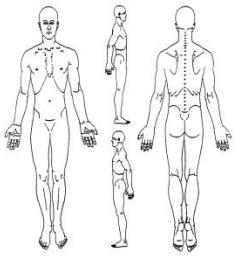
_____

Session summary: _____

Client education: _____

Therapist evaluation of session: _____

___/___/___ Visit # _____ 30-60-90-120 Time:_____ LMT:_____



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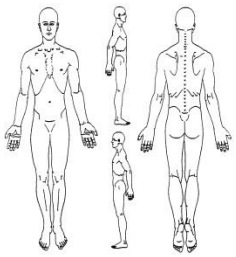

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LMT:_____

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