Keller Family Chiropractic, LLC

10400 LANCASTER- NEWARK RD. MILLERSPORT, OH 43046 TEL: 740.467.2486 FAX: 740.467.2498
GLEN E. KELLER, DC
ERIKA SCHILLING, LMT

Personal Information:

Name:_____ Phone (HOME):_____Phone (CELL)_____
Address:_____
City/ State/ Zip:_____
Email:_____ Date of Birth:_____ Occupation:_____
Emergency Contact:_____ Phone:_____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of Initial Visit (Today's Date):_____

1. Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy?_____

2. Do you have any difficulty lying on your front, back or side? Yes No
If yes, please explain: _____

3. Do you have any allergies to oils, lotions, ointments, trees or nuts? Yes No
If yes, please explain: _____

4. Do you have sensitive skin? Yes No

5. Are you wearing? contact lenses ( ) dentures ( ) a hearing aid ( )?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe: _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe: _____

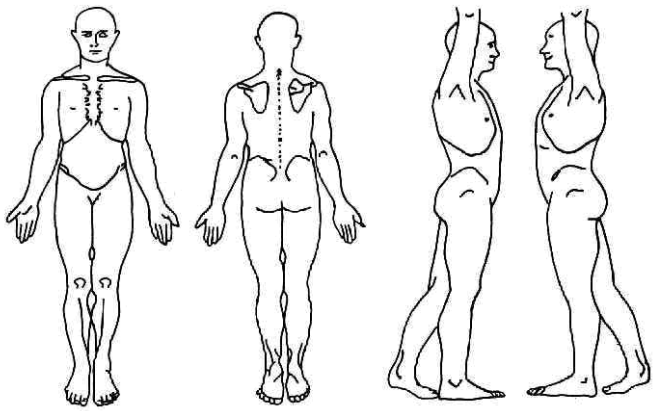
8. Do you experience stress in your work, family or other aspects of your life? Yes No
If yes, how do you think it has affected your health?
muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
If yes, please identify: _____

10. Do you have any particular goals in mind for this massage session? Yes No
If so, what are your goals: _____

11. What level of massage do you prefer?
Deep Medium Light

Please circle any specific areas you would like the massage therapist to concentrate on during the massage session:



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Medical History

In order to plan a massage session that is safe and effective I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No
    If yes, please explain:_____
12. Do you see a chiropractor? Yes No If yes, how often?_____
13. Are you currently taking any medication? Yes No
    If yes, please list:_____
14. Please check any condition listed below that applies to you:

( ) Contagious Skin Condition	( ) Phlebitis
( ) Open Sores or Wounds	( ) Deep Vein Thrombosis (DVT)/ Blood Clots
( ) Easy Bruising	( ) Joint Disorder/ RA/ Osteoarthritis/ Tendonitis
( ) Recent Accident or Injury	( ) Osteoporosis
( ) Recent Fracture	( ) Epilepsy
( ) Recent Surgery	( ) Headaches/ Migraines
( ) Artificial Joint	( ) Cancer
( ) Sprain/ Strain	( ) Diabetes
( ) Current Fever	( ) Decreased Sensation
( ) Swollen Glands	( ) Back/ Neck Problems
( ) Allergies/ Sensitivity	( ) Fibromyalgia
( ) Heart Condition	( ) TMJ
( ) High or Low Blood Pressure	( ) Carpal Tunnel Syndrome
( ) Circulatory Disorder	( ) Tennis Elbow
( ) Varicose Veins	( ) Pregnancy If yes, how many months?
( ) Atherosclerosis	( ) Previous Pregnancies / Including Miscarriages

Please explain any condition that you have marked above_____

_____

_____

15. Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you?_____

_____

Draping will be used during the session - only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

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 and/ or strokes may be adjusted to my level of comfort. I, further understand that massage should not be constructed 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 ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all the 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.

Signature of client:_____ Date:_____
Signature of Massage Therapist:_____ Date:_____