Riverside Chiropractic Center of Seneca, Ltd.

Client History Form

Name:_____Date:_____
Date of Birth:_____Age:_____ Occupation:_____
Home Phone #:_____Work Phone #:_____
Referred By:_____Are you currently pregnant?_____ If yes due date:_____
Is this your first Massage?:_____Primary Reason for Appointment:_____
Are you currently Under the Care of a Physician. If Yes, Please Explain:_____
_____
Physician's Name:_____Phone:_____
If you have had surgery within two years, Details Please:_____
_____

Current Health

Please check if you have any of the following:

___Contact Lenses	___Dentures	___Asthma	___Heart Conditions
___Abdonminal Pain	___Blood Clots	___Varicose Veins	___Spinal Conditions
___High Blood Pressure	___Arthritis	___Infection(s)	___Cancer
___Low Blood Pressure	___Digestion Problems	___Bruise Easily	___Joint Problems
___Circulatory Conditions	___Difficulty Breathing	___Diabetes	___AIDS/HIV
___Osteroporosis	___Migraines	___Pacemaker	___Transdermal Patch
___Muscular Injuries	___Ticklish	___Phlebitis	___Thrombosis

___Respiratory Disease ___Allergies (Please List):_____
___Skin conditions (please list):_____
Do you have any allergies/sensitivities to ___Oils ___Lotions ___Foods
Do you have any other medical conditions which may be pertinant?:_____
_____

Please Mark With an "X" any Areas You Are Feeling Discomfort: