Alexander & Grenon CHIROPRACTIC CENTER, P.C.

Today's Date _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (work/cell) _____ Email _____

Occupation _____ Height _____ Weight _____

Emergency contact name & number _____

Referred by: _____

Are you currently under the care of a physician, chiropractor or alternative medicine practitioner? If yes, what are you being treated for? _____

Please list any medications (prescription or non-prescription), vitamins and supplements you are currently taking: _____

_____

List any known allergies (oils, lotions or ointments). _____

Have you ever had a professional massage before? If yes, how often? _____

Are there any areas you do NOT like massaged ? _____

What do you hope to accomplish with this massage? (i.e. relaxation, decrease back pain, increase flexibility, etc.) _____

_____

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below _____

_____