E. Jade Lynn Howard, LMP
Sloan Family Chiropractic
911 Fifth Avenue, Suite 202
Olympia, WA 98501
360-956-3900

Name:	Nick name:
Address:	Date of Birth:
City, State, Zip	Phone:
Occupation:	Email:
Have you had massage before?	If yes, how often?
When was your last massage:	Did you enjoy it?

Please check any of the following that may apply. A complete history is helpful in producing optimal therapeutic benefit. All information is strictly confidential and voluntary.

___ Sleep Difficulties	___ Insomnia	___ Migraines
___ Neck Pain	___ Low Back Pain	___ Foot Pain
___ Headaches	___ Whiplash	___ Herniated Discs
___ High Blood Pressure	___ Diabetes	___ Heart Condition
___ Fibromyalgia	___ Varicose Veins	___ Fractures
___ Cancer	___ Arthritis	___ Allergies
___ Numbness/Tingling	___ Digestive Difficulties	___ Open Wounds
___ Pacemaker	___ Contact Lenses	___ Inflammation
___ Psoriasis	___ Fungal Infection	___ Infectious Disease
___ Skin Conditions	___ Fatigue	___ Stress
___ Pregnant	___ Prescription Drugs	___ Recreational Drugs
___ Sexual Abuse/Rape	___ Verbal Abuse	___ Domestic Violence

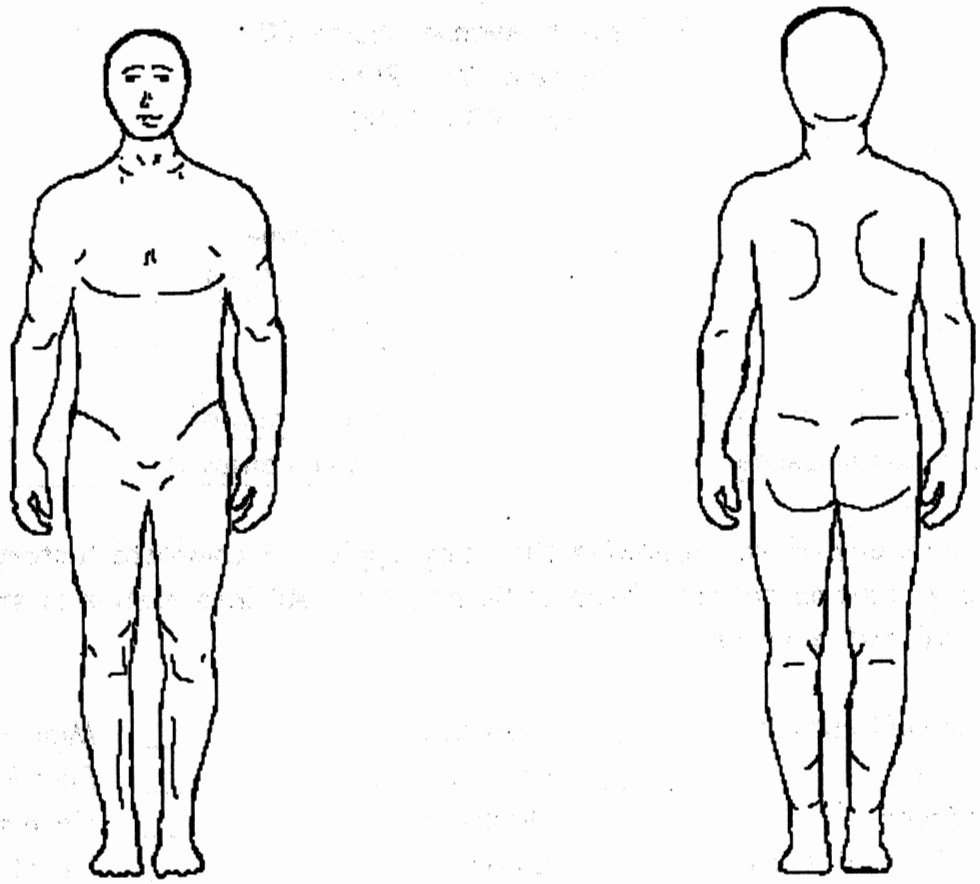
Do you have any recent injuries or illnesses? If yes, please explain:

Physician administering treatment: Name: Number:

What are your reasons for having massage today?

OFFICE USE ONLY:

Please mark any areas on the chart below where you would like to receive focused attention or where you are feeling discomfort.



It is of extreme importance that you feel safe, comfortable and relaxed during your session. Therefore, at all times, such things as stroke pressure, conversation level, sensation strength, room temperature and all other factors that might affect your comfort are entirely your preference.

I, the undersigned, do hereby consent to massage therapy and related modalities. I understand that the services offered are not a substitute for medical care and any information provided is for educational purposes.

Signed: _____ Dated: _____

OFFICE USE ONLY:

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