

Stadelman Chiropractic and Wellness Center
10822 NE 2nd PI Bellevue, WA 98004
425.453.0222 www.drstadelman.com

Name _____ Date _____

Have you ever received massage or bodywork before? (If yes, how was it?)

What (specifically) would you like to receive from this massage?

Would you like me to focus on or stay away from any specific area?

Health Information: Do you have or are you any of the following?

Smoker? Y / N

Contagious Disease? Y / N

Other Heart Conditions? Y / N

Epilepsy? Y / N

Diabetic? Y / N

Cancer? Y / N

Nausea? Y / N

Surgery in last 3 years? Y / N

Pregnant? Y / N

High/Low Blood Pressure? Y / N

Allergies? Y / N

Seizures? Y / N

Varicose Veins? Y / N

Frequent Headaches? Y / N

Dementia? Y / N

Other _____

Are you currently suffering from any pain related to traumatic experience (i.e.: Car accidents, sports injuries, surgeries) Y / N If yes, briefly explain (what and when)

Are you currently taking any medications or supplements (prescription and non-prescript.) Y / N If yes, name(s) of medication(s) and how often taken:

It has been make clear to me that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. I have stated all my known medical conditions and promise to keep the massage practitioner updated on my physical health.

Signature _____ Date: _____