Total Care Chiropractic

22706 Aspan Street, Suite 603-B
Lake Forest, CA 92630
949.380.1166

Client Information

Name: _____ Date: _____

Address: _____ City: _____Sate: __ Zip: _____

Home #: _____ Day Time Phone #: _____

Email address: _____We will only e-mail you special promotions.

Date of Birth: _____ □ Male □ Female

What is your occupation? _____

In Case of Emergency Contact: _____Phone # _____

Referred by_____

Massage History Information

Have you experienced a professional massage? Yes ___ No ___

What pressure do you prefer: □ light □ Medium □ heavy

Areas you would like massage therapist to focus on:

□ head □ neck □ upper back □ shoulder □ mid □ lower back □arm □ hand □ leg □ feet

Are you sensitive to touch/pressure in any area? Yes ___ No ___ If yes, where?_____

Do you have any other medical conditions we should be aware of? Yes ___ No ___ If yes, list any medical conditions_____

Are you allergic to: Apricot oil, Sesame oil, grape seed oil, vegetable glycerin or grape see extract?

Client Consent

I, _____ understand that massage massage is not a substitute for medical examination or diagnoses and that it is recommended that I see a physician for any physical ailment I might have.

I have stated all my known medical conditions and take it upon myself to keep the massage therapist informed of any changes in my physical health.

I understand that payment is due at the time of treatment given unless prior arrangements have been made.

_____ _____

Client Signature Date