St. Clair Chiropractic Clinic, P.C.

301 Trumbull St.
St. Clair, MI 48079

Client Health History

Name____
Address____
City ________________ **State**____________ **Zip**______________
Phone________________ **Cell**____________ **Other**______________
Date of Birth________________ **Occupation**______________________

Circle any conditions that apply.

Allergies Asthma Arthritis Blood Clots Blood Pressure H - L Bone Disease Cancer

Constipation/Diarrhea Dentures Diabetes Digestive Heart Disease Infectious Disease

Jaw Pain Loss of Sensation Stress Tension Varicose Veins
Other____

Are you currently under the care of a physician, other than a chiropractic physician, and/ or taking any medication for any health issues? Y N if yes please explain.

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List past health issues, surgeries and injuries. Please include date of occurrence.

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WOMEN: Are you pregnant? Y N Due Date____________
Do you currently exercise? Y N
Do you regularly stretch? Y N

What is your primary area of concern?

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I understand that Massage Therapy is not a substitute for Medical Treatment and that the Therapist does not diagnose physical or psychological illness. Because the therapist must be aware of existing conditions for the safety of the client and therapist, I have stated all known medical conditions and keep the therapist updated with any changes in my physical health.

Signature__________________________________ Date______________