CORRECTIVE CHIROPRACTIC

The Ultimate in Family Care

Client Intake Form – Therapeutic Massage

Name_____ Phone (Day) _____ Cell_____
Address_____ City/State/Zip_____
Email_____ Date of Birth_____
Referred by _____ Emergency Contact _____

The following information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Have you had a professional massage in the past? Yes _____ No _____
If yes, how often did you receive a massage therapy treatment? _____

Do you have any difficulty lying on your front, back, or side? Yes _____ No _____
If yes, please explain: _____

Do you have any allergies to oils, lotions, ointments, fruits, or nuts? Yes _____ No _____
If yes, please explain: _____

Do you have sensitive skin? Yes _____ No _____

Are you currently wearing any of the following (please check all that apply):

☐ Contact lenses ☐ Dentures ☐ A hearing aid ☐ Prosthetics

Do you sit for 4 or more continuous hours at a workstation, computer, or in a car? Yes _____ No _____
If yes, please explain: _____

Do you perform any repetitive movements in your work, sports, or hobby? Yes _____ No _____
If yes, please explain: _____

As it relates to your health, how do you experience stress from your work, family, or other aspect of your life (please check all that apply)?

☐ Muscle tension ☐ Insomnia ☐ Other_____
☐ Anxiety ☐ Irritability

Is a specific area of the body experiencing tension, stiffness, pain, or discomfort? Yes _____ No _____
If yes, please explain: _____

Do you have any particular goals in mind for this massage session? Yes _____ No _____
If yes, please explain: _____

Medical History

Do you currently or have you ever had any of the following (please check all that apply):

- ☐ Phlebitis
- ☐ Tennis elbow
- ☐ Deep vein thrombosis/blood clots
- ☐ Recent fracture
- ☐ Joint disorder
- ☐ Recent surgery
- ☐ Rheumatoid arthritis/osteoarthritis/ tendonitis
- ☐ Artificial joint
- ☐ Osteoporosis
- ☐ Sprains/strains
- ☐ Epilepsy
- ☐ Current fever
- ☐ Headaches/migraines
- ☐ Swollen glands
- ☐ Cancer
- ☐ Allergies/sensitivity
- ☐ Diabetes
- ☐ Heart condition
- ☐ Decreased sensation
- ☐ High or low blood pressure
- ☐ Back/neck problems
- ☐ Circulatory disorder
- ☐ Fibromyalgia
- ☐ Varicose veins
- ☐ TMJ
- ☐ Atherosclerosis
- ☐ Carpal tunnel syndrome
- ☐ Easy bruising
- ☐ Contagious skin condition
- ☐ Recent accident or injury
- ☐ Open sores or wounds

Are you currently pregnant? Yes _____ No _____
If yes, how many months? _____

Are you currently under medical supervision? Yes _____ No _____
If yes, please explain: _____

Are you currently taking any medication? Yes _____ No _____
If yes, please list all medications: _____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _____
_____
_____

___ **I understand that there is a cancellation fee for massage appointments that are cancelled fewer than 24 hours before my appointment time. I also understand that I am required to pay for half of the massage time that is booked if I do not cancel prior to the 24 hour grace period.**

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis,

or treatment and that I should see a physician/other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and I understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____