Massage Therapy Intake Form

WAGER FAMILY
— CHIROPRACTIC —

Personal Information

Name _____ Phone (day) _____ (mobile) _____

Address _____City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you takingany medications? □ yes □ no

If yes, please list name and use: _____

_____

Are you currently pregnant? □ yes □ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? □ yes □ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? □ yes □ no

If yes, please list: _____

Please indicate any of the following that apply to you.

□ Cancer
□ Fibromyalgia
□ Headaches/Migraines
□ Stroke
□ Arthritis
□ Heart Attack
□ Diabetes
□ Kidney Dysfunction
□ Joint Replacement(s)
□ Blood Clots
□ High/Low Blood Pressure
□ Numbness
□ Neuropathy
□Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

Massage Information

Have you had aprofessional massage before? □ yes □ no

What type of massage are you seeking?

□ Relaxation □ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

□ Light □ Medium □ Deep

Do you have any allergies or sensitivities? □ yes □ no

Please explain _____

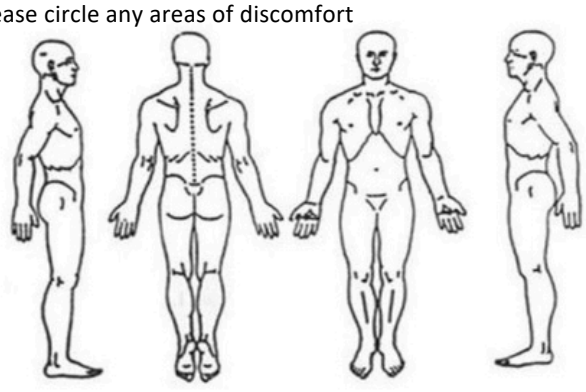
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? □ yes □ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below, you agree to the following.

Ihave completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____