Massage Intake Form

In order to provide you with the best possible massage, please complete this form in its entirety. All information is strictly CONFIDENTIAL.

Client Name: ___________________________ Date: __/__/__
Address: ____
City: ___________________________State:____________ Zip Code ______________
Email: ____
Phone (Day): (____) ________________ Phone (Evening): (____) ________________
Date of Birth: __/__/____ Age: ____
Occupation: ____________________________
Referred By: ___________________________
Do you wear contacts? Yes __ No__ Dentures? Yes__ No__
Please list your primary health care professionals and phone numbers:
(Chiropractor, Osteopath, Nurse Practitioner, ND, MD, etc)

____

____

____

Are you involved in any other therapies at this time? If so, what and how often?

____

____

Are you currently taking medications? For what? Please list:

____

____

Are you currently experiencing bodily tension or tightness? ____If so, where?_____________________________

____

How often do you, on a scale of 1-5 (1 Never, 3 Occasionally, 5 Frequently)
Smoke: ______ Drink Alcohol: ______ Consume Caffeine: ______ Consume Refined Sugar:______
Do you have persistent pain? Yes __No__ Location? ____
Determine degree of pain between 1 and 10 (10 being most painful) ____________________________
When did pain or tension start? ____
Do you associate this condition with a specific activity (work, exercise, etc)? ______________________
If you now have or have had a history of the following, please circle:
High Blood Pressure, Severe Lacerations, Arthritis, Hematomas, Spastic Paralysis, Insomnia, Heart Problems, Fractures, Headaches, Phlebitis, Whiplash, Stiff Neck, Cancer, Constipation, Skin Diseases, Herpes, Diverticulitis, AIDS,
Varicose Veins, Candida, Contagious Diseases
Other__________________
Are you Pregnant? Yes ___ No ___If so, how many months? ________
Please list any previous injuries, such as broken bones, severe sprains, sprains, whiplash, traumas, etc. Provide date(s) of injuries.____

____

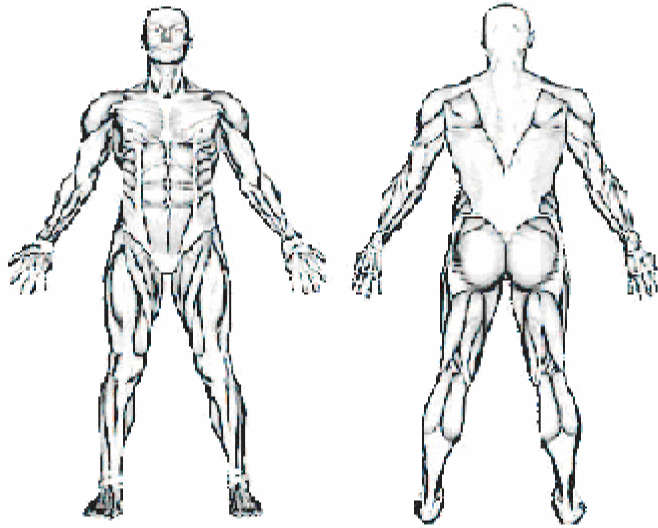
Briefly describe any surgical operations you have had. Provide date(s).____________________________

____

Do you feel as though you "hold" stress or tension in any part of your body? ___Yes ___No
If "yes", is it occasional ______ or frequent ______
Do you experience any of the following :

____Chronic Headaches
____Chronic Backaches
____Bruxism (clenching, grinding of teeth)
____Tightness in the jaw (especially upon waking)

On the diagrams below, please circle those areas that best correspond to the places where you feel you hold stress and/or tension areas where you may be currently experiencing discomfort or pain.



What type(s) of exercise do you do? How often? ____
____
Have you received massage therapy before? Yes____ No_____ With Whom? __________________________
Is there any other information you feel would be helpful to share with me at this time?
____

I understand that the services rendered are not a substitute for medical care and that any information provided is for educational purposes only and not diagnostically prescriptive in nature. I release Active Chiropractic, PC of any responsibility if injuries occur. I agree to actively participate as much as possible in my own healing and growth.

Client Signature: ____Date:_____________