# Massage Therapy Intake

**Office use:** **Patient Number** **Date** **Claim Number**

## Patient Information

Full Legal Name _____ Preferred Name _____
First M.I. Last

Address _____ City _____ Zip _____

Home Phone _____ **Cell Phone** _____ Occupation _____

Age _____ Sex: F M Date of Birth _____ **Email** _____

Emergency Contact _____ Phone _____

## Massage Information

Have you had a professional massage before? Yes No What type of massage are you seeking? Relaxation Therapeutic/Bodywork

What pressure do you prefer? Light Medium Deep Are you sensitive to any fragrances? Yes No

Are you sensitive to pressure & touch in a specific area? Yes No _____

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? Yes No _____

Do you have any difficulty lying on your front, back or side? Yes No _____

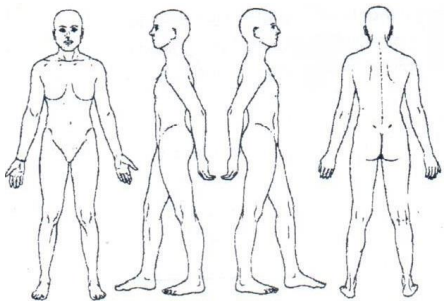
Do you have sensitive skin? Yes No Are you wearing: Contacts Dentures Hearing Aid Prosthetics

Do you sit for long hours at a workstation, computer, or driving? Yes No _____

How do you feel the stress in your life affects your health? Muscle Tension Anxiety Insomnia Irritability Other _____

What are your goals for this treatment session? _____

Please indicate any areas of discomfort by marking the pictures with dots, dashes or circles.



→ Massage Therapist Notes →

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## Medical History

Are you currently under medical supervision? Yes No _____

Do you see a chiropractor? Yes No Do you suffer from chronic pain? Yes No _____

Have you had any orthopedic injuries? Yes No _____

Have you had any surgery's? Yes No _____

Do you have any scars? Yes No _____

Have you had any falls, accidents, injuries, broken bones in the last few years? _____

Are you pregnant? Yes No If yes, how far along are you? _____ Have you had pregnancies in the past? Yes No

Do you take any mediations? Yes No _____

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? _____

_____

_____

Please continue on back side of this page

Santa Clara Chiropractic Center
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Do you currently or have you ever had any of the following?

**Medical History**

_____ Allergies
_____ Arthritis
_____ Atherosclerosis
_____ Breathing Problems
_____ Broken bones
_____ Bruise Easily
_____ Cancer
_____ Carpal Tunnel
_____ Circulatory disorder
_____ Contagious skin condition
_____ Current Fever
_____ Decreased sensation
_____ Depression Anxiety
_____ Diabetes 1 2
_____ Digestive Conditions
_____ Epilepsy or Seizures
_____ Fibromyalgia/Chronic Fatigue
_____ Headaches
_____ Heart Problems
_____ High/Low Blood Pressure
_____ Joint Disorder
_____ Low back pain
_____ Migraines
_____ Neurological
_____ Numbness
_____ Open sores or wounds
_____ osteoporosis
_____ Phlebitis
_____ PTSD
_____ Sciatica
_____ Scoliosis
_____ Shooting Pains
_____ Swollen Glands
_____ Tennis Elbow
_____ Tingling
_____ TMJ
_____ Varicose Veins

Massage Therapist Notes

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I have read the above information and have stated all my known medical conditions. If I experience any pain or discomfort during this session, I will immediately inform the practitioner. I understand that massage/bodywork shou8ld not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any physical or mental ailments that I am aware of. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder and nothing said in the course of the session given should be construed as such. Because massage/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall e no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Patient's Signature _____ Date _____

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