MASSAGE PATIENT INTAKE

ABOUT THE PATIENT

Name _____

Address _____

City _____ State _____

Zip _____ Phone _____

Birth date _____

Cell Phone _____ Carrier _____

Age _____ Gender _____ #Children ____

Employer _____

Marital Status _____ Work Phone_____

May we contact you at work? ◇ Yes ◇ No

Type of Work _____

Social Security # _____

E-mail address _____

Contact via e-mail about appts.? ◇ Yes ◇ No

EMERGENCY CONTACT

Name _____

Relation _____

Home phone _____

Work phone _____

EXPERIENCE WITH MASSAGE or CHIROPRACTIC

Who referred you to this office? _____

Have you seen or heard about us in/on:

◇ Radio ◇ Clinic Sign ◇ Phone Book

◇ Internet ◇ Facebook

Reason for those visits _____

Doctor's/ Therapists name_____

Approximate date of last visit _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to:

◇ Job ◇ Sports ◇ Auto ◇ Fall ◇ Other

◇ Just to Relax ◇ Chronic Discomfort

Please explain _____

_____

_____

When did this condition begin? _____

Has this condition:

◇ Gotten Worse ◇ Stayed Constant

◇ Comes and Goes

Does this condition interfere with:

◇ Work ◇ Sleep ◇ Daily routine

◇ Other Activities

Please explain _____

_____

Has this condition occurred before? _____

Please explain _____

_____

Have you seen other doctors/therapists for this condition?

◇ Yes ◇ No

Doctor's/Therapist Name_____

Type of treatment _____

Results _____

HEALTH HABITS

	Yes	No
Do you smoke?	___	___
Do you drink alcohol?	___	___
Do you drink coffee, tea or soda?	___	___
Do you exercise regularly?	___	___

Medical History

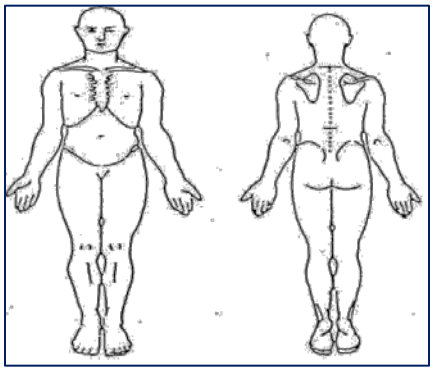
Please indicate below any significant medical problems, as some conditions can influence the type and/or depth of work that can be done in a given area. There are some examples listed but please list **ALL** of the conditions that you have if they apply. Thank you!

- Allergies (ragweed, latex, medications): _____
  _____
- Skin Conditions (acne, rash, skin cancer): _____
  _____
- Lymphatic conditions (swollen glands, lymphoma, lymphedema): _____
  _____
- Circulation conditions (heart disease, varicose veins, previous blood clots, arteriosclerosis):_____
  _____
- Neurological conditions (seizures, epilepsy, numbness/tingling) _____
  _____
- New Injuries or Joint conditions (arthritis, gout, whiplash, sprain) _____
  _____

MEDICATIONS I NOW TAKE. . .(LIST)

- Cholesterol medication_____
- Blood pressure medication_____
- Stimulants_____
- Blood thinners_____
- Tranquilizers_____
- Pain Killers (including aspirin)_____
- Muscle relaxers_____
- Other _____

"MARK" THE AREAS OF CONCERN



HEALTH CONDITIONS

- Headaches
- Neck Pain
- Sleeping Problems
- Back Pain
- Neck Stiffness
- Pins & Needles – Legs
- Pins & Needles – Arms
- Numbness – Fingers
- Numbness – Toes
- Fatigue
- Ears Ring
- Feet Cold
- Hands Cold
- Heart attack/stoke
- Sinus Problems
- High/Low Blood Pressure

Are you pregnant? ◇ Yes ◇ No

Are you nursing? ◇ Yes ◇ No

Are you able to lay on your back?

◇ Yes ◇ No

Can you lay on your stomach?

◇ Yes ◇ No

- Previous Surgeries & Major Injuries: _____