BUCKNER CHIROPRACTIC
& REHABILITATION SERVICES

7185 Highway 72 West, Suite B
Madison, Alabama 35758
(256) 895-0606 • www.bucknerchiropractic.com

MASSAGE AND BODYWORK INTAKE FORM

Today's Date _____

Name Date of Birth _____

Street Phone ( )_____

City_____ State ____ Zip _____ Email_____

Emergency Contact Name and Phone _____ ( ) _____

Referred by _____

Massage History and Session Information

Have you ever received a professional massage? ____No ____Yes

IF YES: Date of Last Massage _____ How often do you get massages? _____

Do you have any specific areas to be addressed? (tension, pain, injury, limited range of motion, etc. and location) _____

_____

What do you spend most of your time doing (occupation, hobbies)? _____

_____

Please list exercise activities and frequency _____

_____

Health Information

Are you currently under the care of a health care practitioner? If so, please specify reason _____

_____

List current medications and reason for taking each _____

_____

Have you had any injuries/accidents/illnesses that are still affecting you? _____

_____

Surgeries: _____

_____

Please mark any of the following that apply.

Musculoskeletal

___Arthritis/Gout

___ Lupus

___ Bone or Joint Disease

Please Specify: _____

___Tendinitis/Bursitis

Where? _____

___Jaw Pain (TMJ)

Not Listed: _____

Skin

___Dry or ___Sensitive Skin

___Skin Allergies - Please Specify:

_____

___Rash (including psoriasis or eczema)

Athlete's Foot

___Herpes/Cold Sores - Currently active? _____

___Warts - Where? _____

Not Listed: _____

Circulatory

___Heart Condition - Please specify: _____

_____

___Phlebitis/Varicose Veins

___Lymphedema/Swelling

___High or ___ Low Blood Pressure

___Blood Clots/Thrombosis/Embolism

Where? _____When? _____

___Poor Circulation

Not Listed: _____

Respiratory

___Breathing Difficulty/Asthma

___Emphysema

___Sinus Problems - Currently bothering? ___

___Allergies - Please Specify: _____

Not Listed: _____

Other

___Pregnancy - Due Date: _____

Cancer - Please Specify: _____

Currently Active? _____

___Fibromyalgia

___Diabetes

___Bladder/Kidney Ailment

___Acid Reflux

___Nausea/Vomiting

___Chronic Pain

___Chronic Fatigue

___Sleep Disorders

___Migraines/Headaches

Frequency: _____

___Depression/Anxiety

___Sensitivity to Smells

___Do you use hormone or steroid creams/gels?

Do you have any other health issues? Please explain _____

_____

I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.

I understand that a massage therapist cannot diagnose illness, disease, or any other medical, physical, or emotional disorder, nor perform spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have. I acknowledge the massage therapist's education, certification, and licensure meet the requirements of the State of Alabama and the National Certification Board of Therapeutic Massage and bodywork, and thereby release the massage therapist from liability of injury.

I understand that massage therapy is a therapeutic health aide and is no-sexual.

I understand that if the massage therapist starts a session late, she will make up the lost time at the end of the session if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me will not be penalized.

Signed _____ Date_____