Client Intake Form – Therapeutic Massage Amesbarry Chiropractic

Today's Date____________________

Name____ Date of Birth____________________

Cell number: _______________________________ Other number______________________________

Address______________________________________City/State/Zip____________________________

Email______________________________________ Occupation _______________________________

Emergency Contact ____ Phone____________________

Name of person who referred you for massage____

The following information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Which type massage do you want? ____Focus on issues ____Relaxation Only ____Both

What level of pressure you would prefer: ____Light ____Medium ____Deep ____I don't know

Have you been involved in a car accident or Work Comp injury in the last 6 months? Yes No

Have you had a professional massage before? Yes No If yes, how often? __________________

Do you prefer talking or silence during your massage sessions? ___________________________

Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain ____

Do you have any allergies to oils, lotions, ointments, fruits or nuts? Yes No
If yes, please explain ____

Do you have sensitive skin? Yes No

Are you wearing: ___ contact lenses ___dentures ___ a hearing aid ___ prosthetics

Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe ____

Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe ____

Please list specific areas of the body where you are experiencing tension, stiffness, pain or discomfort
____

Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain____

Medical History

Do you currently or have you ever had any of the following: (please check)

__ phlebitis	__tennis elbow	__swollen glands
__deep vein thrombosis/blood clots	__recent fracture	__current fever
__ joint disorder	__recent surgery	__ diabetes
__artificial joint	__ headaches/migraines	__heart condition
__ osteoporosis	__sprains/strains	__allergies/sensitivity
__ epilepsy	__ decreased sensation	__high or low blood pressure
__ cancer	__open sores or wounds	
__ back/neck problems	__circulatory disorder	
__ Fibromyalgia	__varicose veins	
__ TMJ	__atherosclerosis	
__ carpal tunnel syndrome	__easy bruising	
__contagious skin condition	__ rheumatoid arthritis/osteoarthritis/tendonitis	

Are you pregnant? ____Yes ____No If yes, how many months?______

Are you currently under medical supervision? Yes No
If yes, please explain____

Do you see a chiropractor? Yes No If yes, how often?____________________________

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? ____

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TREATMENT: I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. **If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort.** I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client ____ Date __________________

PAYMENTS, NO SHOW AND SHORT NOTICE CANCELATIONS:
I understand all payments are due the date of service, with the exception of auto insurance paying for services. I understand this is not being run through my general insurance.
If I do not show up for my appointment or call <u>24 hours</u> in advance to cancel; I understand I personally have to pay $40 for 1 hr appt. $20.00 for 30 min appt. for the time that was blocked for my massage.

Signature of client: ____ Date __________________