

# Client Intake Form – Therapeutic Massage

## Personal Information:

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Home Phone \_\_\_\_\_ CellPhone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Email \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Physician/Healthcare Provider: \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

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

1. Please state your Occupation, if any and describe typical activities of daily living.

\_\_\_\_\_

2. Have you had a professional massage before? Yes No  
If yes, how often do you receive massage therapy? \_\_\_\_\_

3. Do you have any allergies especially to oils, lotions, or ointments? Yes No  
If yes, please explain \_\_\_\_\_

4. Are you currently taking any medications and/or supplements? Yes No  
If yes, please list \_\_\_\_\_

5. **For Women:** Are you currently Pregnant? Yes No  
If yes, what is the due date? \_\_\_\_\_

6. Do you have sensitive skin? Yes No

7. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

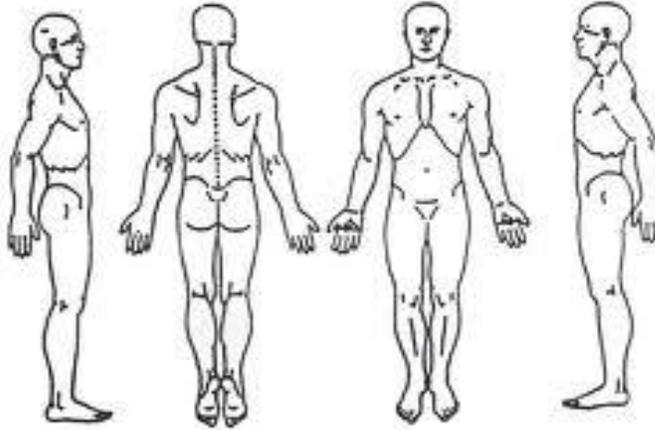
8. Do you perform any repetitive movement in your work, sports, or hobby? Yes No  
If yes, please describe \_\_\_\_\_

9. Please list past injuries or surgeries  
\_\_\_\_\_

10. Indicate any specific areas that are giving you current concern, or that you would like the massage therapist to concentrate on during the session:

P = Pain, ache, tenderness

S= Stiffness in the joint or muscle



11. Rate how you are feeling today by drawing a circle around the number that best represents how you are doing today:

No Pain    0  1  2  3  4  5  6  7  8  9  10    Worst Pain Imaginable

Able to do Everything    0  1  2  3  4  5  6  7  8  9  10    Not Able to do Anything

12. Please check any health condition listed below that currently applies to you.

- contagious diseases
- infections
- blood clots
- pitted edema
- congestive heart failure
- None of the above applies to me**

Please explain any condition that you have marked above

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13. Please circle if you have had any conditions stated below in the past or are currently experiencing these conditions.

- |         |      |                              |         |      |   |
|---------|------|------------------------------|---------|------|---|
| Current | Past | Muscle or joint pain         | Current | Past | Cancer  |
| Current | Past | Muscle or joint stiffness    | Current | Past | Neurological (e.g. MS, Parkinson's, chronic pain) |
| Current | Past | Numbness or tingling         | Current | Past | Memory Loss, confusion, easily overwhelmed        |
| Current | Past | Swelling                     | Current | Past | Epilepsy, seizures                                |
| Current | Past | Bruise easily                | Current | Past | Headaches, Migraines                              |
| Current | Past | Sensitive to touch           | Current | Past | Dizziness, ringing in the ears                    |
| Current | Past | High/Low blood pressure      | Current | Past | Digestive conditions (e.g. Crohn's IBS)           |
| Current | Past | Stroke, Heart attack         | Current | Past | Gas, bloating, constipation                       |
| Current | Past | Varicose vein                | Current | Past | Kidney disease, infection                         |
| Current | Past | Deep vein thrombosis         | Current | Past | Arthritis (rheumatoid, osteoarthritis)            |
| Current | Past | Diabetes                     | Current | Past | Osteoporosis, degenerative spine/disk             |
| Current | Past | Endocrine/thyroid conditions | Current | Past | Scoliosis   |
| Current | Past | Depression, anxiety          | Current | Past | Broken bones                                      |
| Current | Past | Shortness of breath          |         |      |   |

( ) **None of the above applies to me**

Please explain, including treatment received on the **current** conditions you have marked above

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14. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

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**Turn over for last page →**

## Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should 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 mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal 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/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 be 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. Understanding all of this, I give my consent to receive care.

## Ideal Chiropractic & Therapeutic Massage Policies

### Late-Cancellations and No-Shows

We kindly ask that you give us 24 hour notice if you need to cancel an appointment. Late-Cancellations and No-Shows leave gaps in our schedules that cannot be filled without timely notice. This notification courtesy enables us to schedule another patient and, in turn, maintains a higher availability of services for you, as well as others. **Late-cancellations and No-shows will be charged \$40.00.** After-hour messages regarding cancellations may be left at (920) 907-1700.

### Late Arrivals

In consideration of our scheduling commitments to other clients, we may need to reschedule any appointment for which you are more than 15 minutes late. You will be considered a no-show and charged accordingly.

*By signing below, you consent for treatment and acknowledge that you read and understand the policies stated above.*

Print Name \_\_\_\_\_

Signature of client \_\_\_\_\_ Date \_\_\_\_\_