CAROLINA chiropractic • massage • wellness
HEALTH INNOVATIONS

# Massage Therapy Intake Form:

## Client Information

Name:_____ Date: _____

Street:_____ Cell Phone #_____

City:_____State:_____Zip:_____ Home #_____

Email:_____ Work # _____

Occupation:_____ Date of Birth: _____

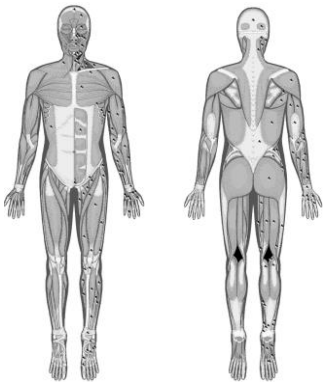
Emergency Contact **Name/Phone #**: _____/_____

Who can we thank for referring you?:_____

## Massage Therapy Information

**Is this your first professional massage? Yes/ No**

**Please Circle the areas of complaint to the right**



Recent activity/event that relates to your areas of Complaint?

_____

_____

| | | | |
|---|---|---|---|
| Do you have diabetes? | Y / N | Do you have a contagious disease? | Y / N |
| Do you experience frequent headaches? | Y / N | Do you have high blood pressure? | Y / N |
| Do you suffer from arthritis? | Y / N | Do you have cancer, past or present? | Y / N |
| Do you bruise easily? | Y / N | Do you have blood clots? | Y / N |
| Do you suffer from epilepsy or seizures? | Y / N | Do you have osteoporosis? | Y / N |
| Do you suffer from joint swelling? | Y / N | Do you have cardiac/circulatory problems? | Y / N |

## Medical History

Are you **currently** under the care of a Health care practitioner? Yes / No

If "Yes", please explain:_____

Describe **ANY** surgeries, hospitalizations, accidents, or injuries you have had:

_____

Please list any medications you are presently using and their purpose:

_____

**Are you currently pregnant? Yes/ No** Not Applicable

Do you have any **chronic**, ongoing **pain** on a regular basis? Yes/ No

If "Yes", please explain: _____

_____

**Would you like to have a Free Consultation with the Chiropractor? Yes No**

## Patient Agreements

- I have completed this form to the best of my knowledge and will inform the massage therapist of any changes in my health.
- It is understood that any inappropriate suggestive remarks or advances will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.
- I agree to give a **24-hour notice** for a scheduled session I cannot keep. I agree to be charged 50% of the service that I do not give a 24-hour notice to cancel or reschedule.
- I agree that if I am late for a service I have scheduled, the therapist may subtract time from my massage as to not penalize the client that may be following my scheduled service.

Patient Name (Signed)_____ Dated_____

Parent/Guardian Signature if under 18 years of age: _____


Copyright 2013, Carolina Health Innovations, Inc.