

Scheetz Chiropractic

Massage Therapy Client Intake Form

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell/Work Phone: _____

Date of Birth: _____ Occupation: _____

Email: _____ Referred by: _____

Are you currently a patient of Scheetz Chiropractic? Yes / No

Previous experience with massage: _____

Primary reason for appointment/areas of pain or tension: _____

Emergency contact (name and number): _____

Please mark (X) for all conditions that applies now, (P) for past conditions, and an (F) for family history of illness.

Pain Scale: minor-1	2	3	4	5	6	7	8	9	10-severe
____ headaches, migraines			____ chronic pain				____ fatigue		
____ vision problems, contact lenses			____ muscle or joint pain				____ tension, stress		
____ hearing problems, deafness			____ muscle, bone injuries				____ depression		
____ injuries to face or head			____ numbness or tingling				____ sleep difficulties		
____ sinus problems			____ sprains, strains				____ allergies, sensitivities		
____ dental bridges, braces			____ arthritis, tendonitis				____ rashes, athlete's foot		
____ jaw pain, TMJ problems			____ cancer, tumors				____ infectious disease		
____ asthma or lung conditions			____ spinal column disorders				____ blood clots		
____ constipation, diarrhea			____ diabetes				____ varicose veins		
____ hernia			____ pregnancy				____ birth control, IUD		
____ high/low blood pressure			____ heart, circulatory problems				____ STD(s)		
____ abdominal/digestive problems			____ other medical conditions not listed						

Explain any areas noted above: _____

Current medications (including aspirin, ibuprofen, herbs, supplements, etc.): _____

Surgeries: _____ Dates: _____

Accidents: _____ Dates: _____

Please list all forms and frequency of stress reduction activities, hobbies, exercise or sports participation:

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing, and reduce muscular tension, it is not a substitute for medical examination, diagnosis, and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize *Lynelle Robieson, L.M.T.* to administer massage therapy techniques to my child or dependent as she deems necessary.

Signature of Parent or Guardian: _____ Date _____