

Massage Patient Intake Form

Name: _____ **Date:** _____

1. **What is your goal of your massage therapy?** Relaxation Therapeutic Both

2. **Are you a current patient of Dr. Christina Carter's?** Yes No

 If yes, may I speak with her concerning your care? Yes No

 If no, are you currently receiving chiropractic care? Yes No

3. **Do you currently have a Primary Care Doctor?** Yes No

 If yes, what is their name or practice: _____

4. **What areas would you like your massage therapy to focus on?**

5. **What are your areas of chronic discomfort or pain?** None

6. **Have you had a professional massage before?** Yes No

7. **What is your pressure preference?** (mark a range below)

Extremely Light ----- Medium----- Very Deep

8. **Areas of your body you would like me to AVOID?**

Scalp Face Neck Pecs Low Back Glutes Feet Other: _____

9. **Are you allergic to anything?** Yes No

 If yes, explain: _____

10. **Have you had any surgeries?** Yes No

 If yes, explain: _____

11. **Have you been in a recent accident, injury or fall?** Yes No

 If yes, please give details: _____

12. How talkative do you prefer your massage therapist to be? (mark a range below)

Don't Care Quiet ----- Talkative

13. What medications are you currently taking? and why?

Medication Name	Reason you take it
_____	_____
_____	_____
_____	_____
_____	_____

14. (**Women only**) Are you pregnant? No Yes, _____ months along

If yes, please fill out the "Prenatal Massage Release Form".

15. Please check all that apply to you now or in the past and give any needed details on the line below:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Open Sores/Wounds | <input type="checkbox"/> Whiplash | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Broken/Dislocated Bone | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Seizures | <input type="checkbox"/> Skin conditions | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Autoimmune Disorder (RA, lupus, MS) | <input type="checkbox"/> Other: _____ | | |

So that we can give you the best possible quality massage please initial beside the following statements:

_____ (**initial here**) This is a therapeutic massage and any sexual remarks or advances will immediately terminate the session and no refund will be provided.

_____ (**initial here**) If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or method of massage may be adjusted to my comfort level.

_____ (**initial here**) I understand that although Massage Therapy can be therapeutic, relaxing, and reduce muscular tension, it is not a substitute for medical examination, diagnosis and/or treatment.

Massage Cancellation Policy:

More than 48 hour notice – no penalty

Less than 48 hour notice - \$20 for 30 min, \$40 for 60 min, \$60 for 90 min

Less than 24 hour notice or no show – full price of massage

By signing below, I agree to these terms & authorize Adjust Your Health Chiropractic to charge the card they have on file.

Patient/Guardian Signature: _____ **Date:** _____