CREEKSIDE
Chiropractic & Massage, PS

EKSIDE
Chiropractic & Massage, PS

Massage Intake Form

Name_____ Occupation_____

Date of Birth_____ SSN_____

Address_____

State_____ City_____ Zip _____

Cell Phone_____ Home Phone_____

Work Phone _____ Email address_____

Would you like to receive text and/or email reminders? Yes to both Yes, _____ No

How did you hear about us? (So we know who to thank.) :

Family_____ Internet Yellow Pages

Friend_____ _____ Other, please specify:

Co-Worker_____ Primary Care_____ _____

Marketing Event _____

Have you ever received massage therapy? Yes No

Type of massage experienced (Swedish, shiatsu, deep tissue, etc.)_____

Are you currently taking any medications? Yes No

If yes, please list names and reason/treatment:

_____

_____

Are you currently seeing a healthcare professional? Yes No

If yes, please list names and reason/treatment:

_____

_____

Do you have any of the following today:

_____ skin rash _____ cold/flu _____ open cuts

_____ anything contagious _____ injuries/bruises _____ severe pain

Are you wearing: _____contact lenses _____hearing aid _____hairpiece

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

____ arthritis
____ depression
____ pain disorder
____ other psych condition
____ diabetes
____ blood clots
____ diverticulitis
____ broken/dislocated bones
____ headaches
____ bruise easily
____ heart condition
____ cancer
____ back problems
____ chronic pain
____ high blood pressure
____ constipation/diarrhea
____ insomnia
____ auto-immune condition*
____ muscle strain/sprain
____ hepatitis (A, B, C, other)
____ pregnancy
____ skin conditions
____ scoliosis
____ stroke
____ seizures
____ surgery
____ whiplash
____ TMJ disorder
____ chemical dependency (alcohol, drugs)
____ other:_____

If any of the above needs to be detailed or if there is anything else to share, please do so:

Do you have any allergies to:

____ medications ____ reaction to skin care products ____ food (nuts, etc.)

____ environmental allergens (dust, pollen, fragrances)

What are your goals/expectations for this therapy session?

_____

_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:

✱ sighing, yawning, change in breathing ✱ stomach gurgling ✱emotional feelings and/or expression ✱

✱ memories ✱ movement of intestinal gas ✱ energy shifts ✱ falling asleep ✱ need to change position ✱

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: _____