Chiropractic Family Wellness Center

Massage Intake Paperwork

Name: ____ Date of Birth: ___/___/___

Address:____

City: ____________________________State: ______________ Zip Code:_________________________

Phone Number:___________________________ Occupation:___________________________________

Who may we thank for your referral? ____

Have you Ever received a professional Massage: □ Yes □ No Last treatment:____________________

What type of touch do you prefer? □ Light/Medium □ Medium/Deep □ Deep/Trigger Point

Do you have any of the following?

□ Asthma
□ Diabetes
□ Varicose Veins
□ Epilepsy
□ Skin Conditions
□ High/Low Blood Pressure
□ Heart Disease
□ Arthritis
□ Stomach Ulcers
□ Dizziness
□ Pacemaker
□ Easily Bruised
□ Hemophilia
□ Musculoskeletal Problems
□ Pregnancy
□ Headaches
□ Hernia
□ Cancer
□ Depression
□ Phlebitis

Do you have any allergies? ____

Are there any other Health Conditions we should be aware of? □ Yes □ No
If **Yes**, please explain: ____

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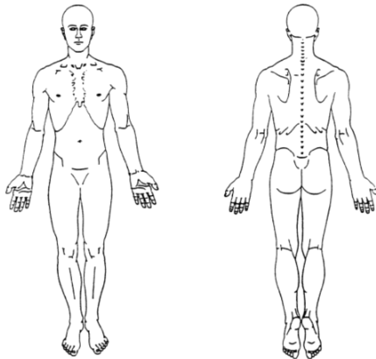

Please mark on the chart your areas of discomfort.

What is your major complaint? ___________________________

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I understand that the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension or spasm, and/or improving circulation. I understand that a massage therapist neither diagnoses illness, disease, or any other medical, physical, or mental disorders – nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailment I may have.

Signature:____ Date:____________________________