MAPLEBROOK CHIROPRACTIC

Maplebrook Chiropractic – Dr. Nadia Carpanzano, D.C.
365 E. Bailey Road   Naperville, IL 60565
630.536.8002

Client Intake Form – Therapeutic Massage

Personal Information:

Name: ____________________ **Home Phone:** ____________ **Cell Phone:** ____________

Address: ____

City/State/Zip: ____

E-Mail Address: ____________________ **Date of Birth:** ____________ **Occupation:** ____________

Emergency Contact: ____________________ **Cell Phone:** ____________ **Relation:** ____________

Date of Initial Visit: ____________________ **How did you hear about us?** ____________________

The following information will be used to help plan safe and effective massage sessions. Please answer the following questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No
   If yes, how often do you receive massage therapy? ____________________
2. Are you interested in receiving a massage on a regular basis for a discounted rate? Yes No
3. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain. ____________________
4. Do you have sensitive skin or any skin conditions? Yes No
5. Do you currently have pain that negatively affects your activities of daily living? Yes No
   If yes, please explain. ____________________
6. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please explain. ____________________
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please explain. ____________________
8. Do you experience stress in your work, family, or other aspect of your life? Yes No
   If yes, how do you think it has affected your health?
   Muscle tension ( )   Anxiety ( )   Insomnia ( )   Irritability ( )   Other ( ): ____________
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? Yes No
   If yes, please identify. ____________________
10. Do you have any particular goals in mind for this massage session? Yes No
    If yes, please explain. ____________________

Medical History:

11. Are you currently under medical supervision? Yes No
    If yes, please explain. ____________________
12. Do you see a chiropractor? Yes No
13. Are you currently taking any medication? (i.e. Blood Thinners, etc.) Yes No
    If yes, please list. ____________________

Continued On Reverse Side

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14. Please check any category listed below in which a medical condition exists:

Musculoskeletal	( )	Skin	( )	Contact Lenses	( )
Circulatory	( )	Digestive	( )	Dentures	( )
Pressure	( )	Psychological	( )	Hearing Aids	( )
Respiratory	( )	Pregnant	( )	Broken Bones	( )
Nervous System	( )	Cancer/Tumors	( )	Surgeries	( )
Reproductive	( )	Diabetes	( )		

Please explain any condition that you have marked above or anything else about your health history that you think might be useful for your massage therapist to know to plan a safe and effective massage session for you.

____

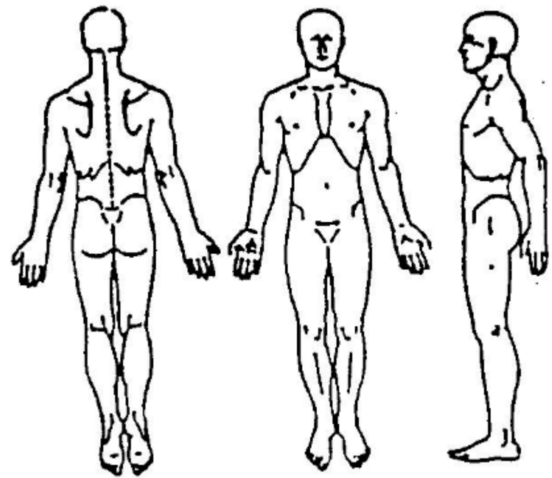
____

15. Please circle any specific areas where you feel pain, discomfort, stiffness, tension as these may be areas that you would like your massage therapist to focus on during today's session:

Please list areas in this box that you would like your therapist to avoid:

____

____



I understand that a licensed massage therapist, an independent contractor of Maplebrook Chiropractic LLC, will conduct my massage session. I acknowledge that draping will be used during the session and only the area being worked on will be uncovered.

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

FEMALE CLIENTS: Based on your request, your massage therapist may work on your pectoral muscles near your chest. Please check [ ] if you would rather not have this area worked on during your treatment session.

I understand that I am responsible for all costs of therapeutic massage, regardless of possible insurance coverage or any personal injury case. I further accept Maplebrook Chiropractic's 24-hour cancellation policy. Clients must re-schedule or cancel their appointments with at least a 24-hour notice. Appointments missed or cancelled with less than 24 hours can be billed as there are staff and schedule requirements that are made when the client is expected at the office.

Client Signature: ____ **Date:** ____________________

Note: Informed written consent must be provided by parent or legal guardian for any client under the age of 18.