Dr. Michael Zdilla
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# Massage Therapy Intake

Today's Date

## PATIENT INFORMATION

***Please take the time to breathe and relax as you complete this form prior to your massage. All information will be kept confidential.***

Name: Last First MI DOB Age Sex M or F

Home Address: City State Zip

| | | |
|---|---|---|
| Home Phone #: ( ) - | May we leave a message? □ Yes □ No | Occupation: |
| Work Phone #: ( ) - | May we leave a message? □ Yes □ No | Referred By: |
| Cell Phone #: ( ) - | May we leave a message? □ Yes □ No | Have you ever had a professional massage? □ Yes □ No |
| Email: | May we send a message? □ Yes □ No | |

Emergency Contact: Name Phone Relationship

Are you currently under the care of a Health Professional for any medical treatment? □ Yes □ No
If yes, please explain:

Primary reason for appointment(check all that apply): □ Relaxation □ Stress □ Injury/Pain (complete section below) □ Other

Pregnant/Past Pregnancy
Have you had any complications with this pregnancy or experienced any in the past? □ Yes □ No
If yes, please explain:

Permission to touch the abdomen during your Pregnancy Massage? □ Yes □ No

## If the reason for your appointment is injury/pain, please answer the following questions.

The problem(s) I want the massage therapist to help me with is/are:
□ Area of Pain:

How long ago did this problem first start? ________ (#) □ Days □ Weeks □ Months □ Years

Did your pain or problem: □ Begin all of a sudden □ Gradually develop over time

What aggravated or caused these *current* symptoms?

Have you had these symptoms/conditions in the past? □ Yes □ No If yes, when?

Since the time your pain or problem began, has it: □ Stayed the Same □ Become Worse □ Improved

Are you being treated by any other healthcare provider for this condition? □ Yes □ No
If yes, by whom? For what?

What treatments have you had for this problem?

Does it... □ bother you at work? □ bother you at rest? □ wake you from a sound sleep?

What makes it better?

What makes your pain or problem feel worse? □ Walking □ Standing □ Daily Activities □ Resting □ Running □ Other

Are there sensations (pain, tingling, etc.) that travel away from the main location into neighboring areas? □ Yes □ No

Have you seen a chiropractor before? □ Yes, when? □ No
If yes, by whom? For what?

How has this problem affected your lifestyle or ability to work?

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# MEDICAL HISTORY

***Please check the box of all conditions you presently have or have had in the past. We need your complete health history before we can be responsible for your care.***

| Muscle/Joint | Eye, Ear, Nose and Throat | Women ONLY | Additional Conditions |
|---|---|---|---|
| □ Arthritis | □ Deafness | □ Birth Control | □ AIDS/HIV |
| □ Bursitis | □ Ear Discharge | □ Cramps | □ Alcoholism |
| □ Neck Pain | □ Ear Noise | □ Heavy Menstruation | □ Anemia |
| □ Mid Back Pain | □ Cataracts | □ Hot Flashes | □ Anorexia/Bulimia |
| □ Low Back Pain | □ Eye Pain | □ Irregular Cycle | □ Auto Accident |
| □ Jaw/TMJ Pain | □ Near/Farsighted | □ Lumps in Breast | □ Autoimmune Disease |
| □ Herniated Disc | □ Glaucoma | □ Menopause | □ Cancer |
| □ Rheumatoid Arthritis | □ Nasal Obstructions | □ Miscarriage | □ Chicken Pox |
| □ Osteoarthritis | □ Nose Bleeds | □ Pelvic Pain | □ Depression |
| □ Osteoporosis | □ Sinus Infections | □ Vaginal Infections | □ Diabetes |
| □ Sciatica | □ Tonsilitis | □ Pregnant # of Months___ | □ Epilepsy |
| □ | □ | □ | □ Fractures |
| **General** | **Genitourinary** | **Skin** | □ Hepatitis |
| □ Convulsions/Seizures | □ Blood in Urine | □ Bruise Easily | □ Herpes |
| □ Dizziness/Fainting | □ Frequent Urination | □ Dryness | □ Immunosuppressed |
| □ Excessive Fatigue | □ Incontinence | □ Hives/Rashes | □ Inflammatory Disease |
| □ Excessive Nausea | □ Kidney Infection | □ Mole Changes | □ Lipoaspiration/suction |
| □ Excessive Sweating | □ Kidney Disease | □ Mole Surgeries | □ Long-Term Steroid Tx |
| □ Headache/Migraine | □ Painful Urination | □ Skin Eruptions | □ Medical Implants |
| □ Head Trauma | □ Prostate Condition | □ Tattoos | □ Metal Pins/Plates |
| □ Memory Loss | □ Urine Infection/UTI | □ Varicose Veins | □ Multiple Sclerosis |
| □ Nervousness | □ | □ Infections | □ Mumps |
| □ Depression | **Respiratory** | □ | □ Parkinson's Disease |
| □ Sleep Changes | □ Asthma | **Gastrointestinal** | □ Photosensitivity |
| □ Weight Changes | □ Bronchitis | □ Appendicitis | □ Piercings |
| □ | □ Chronic Cough | □ Bloody/Black Stools | □ Polio |
| **Cardiovascular** | □ Emphysema | □ Colitis | □ Radiation Treatment |
| □ Bleeding Disorders | □ Pneumonia | □ Colon Condition | □ Rheumatic Fever |
| □ High/Low BP | □ Spitting up Blood | □ Constipation | □ Scarlet Fever |
| □ Heart Pain | □ Tuberculosis | □ Frequent Diarrhea | □ Steroid Use |
| □ Poor Circulation | □ Wheezing | □ Indigestion | □ Stroke |
| □ Rapid/Slow Heart Beat | □ Whooping Cough | □ Pain with Swallowing | □ Suicide Attempt |
| □ Pacemaker | □ | □ Hernia | □ Thyroid Problems |
| □ High Cholesterol | | □ Pancreatitis | □ Tumors |
| □ Cardiac Arrhythmias | | □ Reflux Disease | □ Venereal Diseases |
| □ Heart Disease | | □ Liver Disease | □ |
| □ Medical Edema | | □ | □ |
| □ Blood Thinners | | | □ |
| □ Phlebitis (red hot calves) | | | □ |
| □ | | | □ |

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## MEDICAL HISTORY (cont)

**Please list all medications you are currently taking (include all Prescriptions, Over-the-counter meds, Vitamins, Herbals and/or Supplements):**

| Name | Taken for what condition? | Dose | How often do you take? | I first began this medicine(mo/yr) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |

**Please list all prior injuries and/or surgeries:**

| Type of Injury/Surgery | Date |
|---|---|
| | |
| | |
| | |
| | |

**Please list all prior hospitalizations(other than for surgery):**

| Reason for Hospitalization | Date |
|---|---|
| | |
| | |

**Allergies:** ☐ None Known
☐ Yes (please list)

| **Examinations:** | | | | | |
|---|---|---|---|---|---|
| | Spinal X-Ray | ☐ Never | ☐ 0-12 mo. | ☐ 1-3 yrs. | ☐ Longer |
| | Spinal Exam | ☐ Never | ☐ 0-12 mo. | ☐ 1-3 yrs. | ☐ Longer |
| | Physical Exam | ☐ Never | ☐ 0-12 mo. | ☐ 1-3 yrs. | ☐ Longer |

## FAMILY HISTORY

***Check all that apply and describe which FAMILY MEMBER is involved. Immediate family only.***

☐ Cancer ☐ Diabetes ☐ Lung Disease ☐ Heart Disease
☐ Musculoskeletal ☐ Gastrointestinal Disease ☐ Genitourinary Disease ☐ Joint Disease
☐ Other ______________________________________________

## SOCIAL HISTORY & LIFESTYLE QUESTIONS

**Use of Alcohol:** ☐ Never ☐ No Longer Use ☐ History of Alcohol Abuse
☐ Current Use: Type ____________________ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

**Use of Tobacco:** ☐ Never ☐ Type ________________☐ Smoke_____Pack(s)/Day for _____Years ☐ Quit-How Long Ago?

**Use of Recreational Drugs:** ☐ Never ☐ Quit-How Long Ago and Type?_______________________________________________
☐ Current Use: Type____________________ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily Needles in the Past: ☐ Yes ☐ No

**Use of Caffeine: (soda, coffee, tea, etc.)** ☐ Never ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily: how many per day?

**Exercise:** ☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several Times a Week ____ (#) ☐ Daily
Types of Exercise:__________________________________________________________________________________
I consider this to be: ☐ Light ☐ Moderate ☐ Heavy

Do you wear contact lenses? ☐ Yes ☐ No Do you have dentures/hearing aids? ☐ Yes ☐ No

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## Consent

**Appointment/Cancellation - At Zdilla Family Chiropractic (ZFC), we understand that unanticipated events occur in everyone's lives. However, out of respect for both our therapist(s) and the clients who are trying to rearrange their busy schedules, we ask that you do your very best to not cancel appointments last minute or miss your scheduled appointment as this deprives us of the chance to provide service to someone else. In our commitment to provide an outstanding experience to all of our clients and out of consideration for our therapists time, we have adopted the following policies:**

**1.)24 hours notice is required to cancel or reschedule an appointment.**
**2.)If you fail to provide 24 hours notice or do not show for your appointment you will be charged a cancellation fee. The fee is 50% of your scheduled appointment cost.**
**3.)If you are late, your session may be shortened or cancelled in order to accommodate others whose appointment follow yours or you may be charged according to the cancellation policy. The fee may be waived under certain circumstances.**

**To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the therapist and office staff of any changes to my address, phone number, personal information or my medical status. I understand and agree to the terms, policies and information within this document.**

**We reserve the right to refrain from providing a massage service or anything that may be contraindicated until written permission is given by your medical professional.**

**I understand that it is my choice to receive massage therapy for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow. I understand that the massage therapist does not diagnose illness, or disease, nor do they prescribe any medical treatments. I acknowledge that massage is not substitute for medical examination or diagnosis, and it is recommended that I see a health care provider for that service. I also understand that the information given above is strictly confidential and failure to disclose information could result in injury and/or illness. Lastly, it is understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the scheduled appointment. Any information provided to me by the massage therapist is for general purposes only.**

**Print Name of Client, Parent or Guardian**

**Signature of Therapist**

**If Other Than Patient, Relationship to Patient**

**Date**

**Signature** **Date**