ACA Massage Intake Form

Name _____ Date of Birth _____

Address _____ City_____ State _____ Zip _____

Phone _____ Email _____

Occupation _____ Employer_____ Phone _____

Please answer the questions to the best of your knowledge.

Have you experienced a professional massage before? Yes ☐ No ☐ If yes, how recently? _____

What are your goals with this massage session? _____

Please describe any activities that worsen your condition: _____

_____

What intensity do you prefer for your massage? Light Moderate High

Do you have a difficult time lying on your front, back, or side? Yes ☐ No ☐

Do you like music playing during your massage? Yes ☐ No ☐

Do you like conversation during your massage? Yes ☐ No ☐

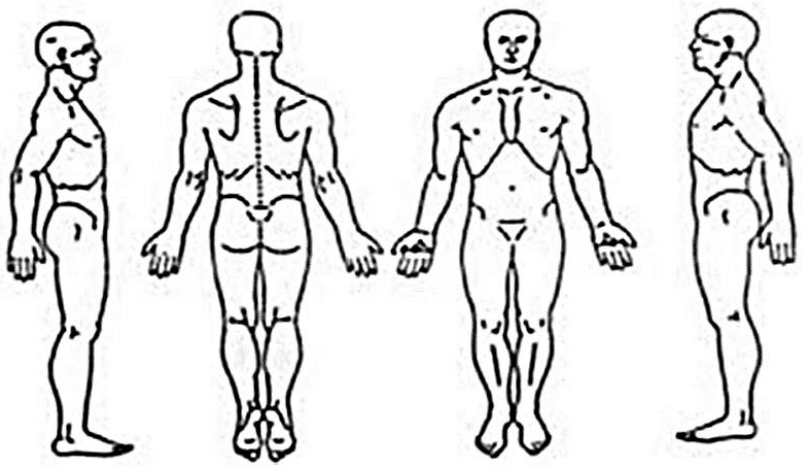
Please list any medications you take and reason for the medication _____

_____

Whom may we thank for referring you to our office? _____

What brings you into the office today? _____

Circle any specific areas you would like the massage therapist to concentrate on during this session.



When did it start? _____

How did it happen? _____

OVER →

Please check the appropriate box for all the following items and please explain as clearly as possible

Yes	No		Yes	No	
☐	☐	Stress	☐	☐	Circulatory disorder
☐	☐	Contagious skin disease	☐	☐	Varicose veins
☐	☐	Open sores or wounds	☐	☐	Phlebitis
☐	☐	Easy bruising	☐	☐	Deep vein thrombosis/ blood clots
☐	☐	Recent accident or injury	☐	☐	Joint disorder
☐	☐	Recent fracture	☐	☐	Rheumatoid arthritis/ osteoarthritis/ tendonitis
☐	☐	Recent surgery	☐	☐	Osteoporosis
☐	☐	Artificial joint	☐	☐	Headaches/ migraines
☐	☐	Sprains/ strains	☐	☐	Cancer
☐	☐	Current fever	☐	☐	Diabetes
☐	☐	Swollen glands	☐	☐	Decreased sensation
☐	☐	Allergies	☐	☐	Back/ neck problems
☐	☐	Allergy to oils, lotions, or ointments	☐	☐	Fibromyalgia
☐	☐	Sensitive skin	☐	☐	Carpal tunnel syndrome
☐	☐	Heart Condition	☐	☐	Temporomandibular joint dysfunction (TMJ)
☐	☐	High or low blood pressure	☐	☐	Tennis elbow
☐	☐	Other _____	☐	☐	Pregnant? If yes, what trimester? _____

Please explain all "yes" answers _____

_____

_____

Consent for Treatment

Assignment & Release - ***By signing below, I authorize Arlington Chiropractic & Acupuncture to release medical records required as deemed necessary. I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for payment at time of service. I understand that this office does not accept Medicaid. I understand that this office does submit insurance and Medicare claims. By signing below, I give my consent massage therapy and/or cupping examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient. As with any healthcare procedure, there are certain complications which may arise during massage therapy. These complications include but are not limited to: bruising, skin irritation, allergic reaction, minor aches and pains, burning, etc. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.***

_____ _____

Patient Signature Date