Panacea Naturopathic LLC

Chair Massage Intake

Client Information

PAT#_____

Please complete and sign

First Name:_____ Middle Initial:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Gender: Male Female Other

Home Phone:_____ Cell Phone:_____

How did you hear about us?_____

Please take time to accurately fill out the following questions to the best of your knowledge, as chair massage may be indicated or contraindicated for you today. Certain medical conditions may require a referral or permission from your doctor. Thank you for your time!

1. Have you ever experienced a professional massage before?	Yes	No	
2. Do you currently have tension or soreness in any specific area?	Yes	No	
3. Do you frequently suffer from stress?	Yes	No	
4. Are you pregnant?	Yes	No	N/A
5. Do you have arthritis?	Yes	No	
6. Do you have osteoporosis?	Yes	No	
7. Have you had any serious injuries in the past two years?	Yes	No	
8. Have you had any recent surgeries?	Yes	No	
9. Are you currently taking any medications?	Yes	No	

Explain any Yes answers: _____

_____

_____

Client/Therapist Release & Agreement

I understand that the massage work I receive is provided for the basic purpose of 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 altered or stopped. I affirm that I have stated all my known medical conditions and have answered all questions honestly.

I authorize the massage therapists to render chair massage to me (or my dependent/minor child).

Client Signature:_____ **Date:**_____

(Or client's parent/guardian, if under 18 years of age)

For Office Use Only