

# Back to Life Chiropractic Center

## Massage Intake Form

### Personal Information

Name \_\_\_\_\_ Phone (day) \_\_\_\_\_ (evening) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ DOB \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Email \_\_\_\_\_ Primary Physician \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### Medical Information

Are you taking any medications?  yes  no

If yes, please list name and use: \_\_\_\_\_

Are you currently pregnant?  yes  no

If yes, how far along? \_\_\_\_\_

Any high risk factors? \_\_\_\_\_

Do you suffer from chronic pain?  yes  no

If yes, please explain \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Have you had any orthopedic injuries?  yes  no

If yes, please list: \_\_\_\_\_

Please indicate any of the following that apply to you.

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fibromyalgia       |
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Attack       |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s)    | <input type="checkbox"/> Blood Clots        |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness           |
| <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Sprains or Strains |

Explain any conditions you have marked above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Massage Information

Have you had a professional massage before?  yes  no

What type of massage are you seeking?

- Relaxation  Therapeutic/Deep Tissue

Other \_\_\_\_\_

What pressure do you prefer?

- Light  Medium  Deep

Do you have any allergies or sensitivities?  yes  no

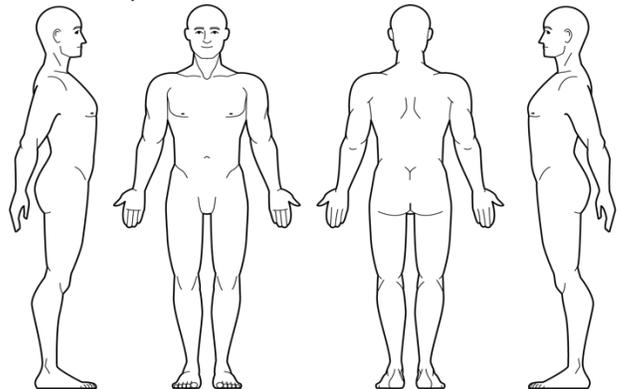
Please explain \_\_\_\_\_

Are there any areas (feet, face, abdomen, etc.) you do not want massaged?  yes  no

Please explain \_\_\_\_\_

What are your goals for this treatment session?

Please circle any areas of discomfort



*By signing below, you agree to the following: I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscle tension, it is not a substitute for medical examination, diagnosis or treatment. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions regarding medical history thoroughly and truthfully.*

Client Signature \_\_\_\_\_ Date \_\_\_\_\_