RIVERCREST CHIROPRACTIC

Client Intake Form- Massage Therapy

Personal Information:

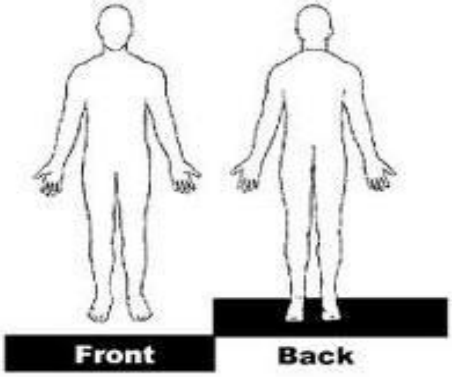
Name_____
Phone (Day) _____ Phone (Eve)_____
Address_____City_____
State_____Zip_____ Email _____
Date of Birth _____Occupation_____
How were you referred to us? _____
Emergency Contact _____Phone_____

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

Date of Initial Visit_____

1. Have you had a professional massage before? Yes No
   If yes, how often do you receive massage therapy? _____
2. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain _____
3. Do you have any allergies to oils, lotions, or ointments? Yes No
   If yes, please explain _____
4. Do you have sensitive skin? Yes No
5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?
6. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please describe _____
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please describe _____
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 _____

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



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Medical History

In order to plan a massage session that is safe and effective,
I need some general information about your medical history.

12. Do you currently see a chiropractor? Yes No If yes, how often? _____
    If no, would you be interested in speaking with one of our Doctors for a complimentary consultation? Yes No
11. Are you currently under medical supervision? Yes No
    If yes, please explain _____
13. Are you currently taking any medication? Yes No
    If yes, please list _____
14. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months? _____
( ) recent accident or injury If yes, when? _____

Please explain any condition that you have marked above_____
_____
_____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____
_____
_____

Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 17, must have written consent provided by parent or legal guardian and/ or may need to be accompanied by a parent or legal guardian during the entire session.

I, _____ (print name) 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.

Signature of Client _____ Date_____

Signature of Massage Therapist _____ Date _____