Manchester Family Chiropractic Center

NEW MASSAGE PATIENT INTAKE

PATIENT INFORMATION

Date ____________________

Patient____

Address____

City__________________State__________Zip___________

Sex: ◊ M ◊ F Age: _________DOB:___________________

◊Single ◊Married ◊Divorced ◊Widowed ◊Separated

Whom may we thank for referring you? ________________

____

PHONE NUMBERS

Home ________________Cell________________________

Work ____

Email____

Best time/place to contact you ◊AM ◊PM ◊Home ◊Cell

In case of emergency, contact:

Name_____________________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. Do you have any difficulty lying on your front, back or side?________ If yes please explain:
   ____
2. Do you have any allergies to perfume, oils, lotions, or ointments?_______ If yes please explain:
   ____
3. Are you wearing contact lenses ☐ dentures ☐ a hearing aid ☐ ?
4. Do you sit for long hours at a workstation ☐, computer ☐, or driving ☐ ?
5. Do you perform any repetitive movement in your work, sports, or hobby?_____ If yes, please describe:
   ____
6. On a scale of 1 – 10, what is your daily stress level? _________________
7. Do you have any particular goals in mind for this massage session? _________ If yes, please explain:
   ____

Medical History

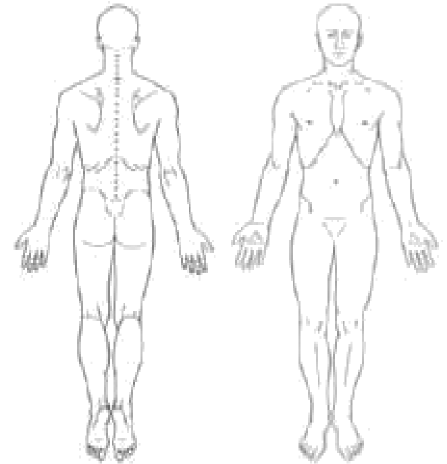
In order to plan a massage session that is safe and effective, I need some general information about your medical history.

1. Are you currently under medical supervision for any specific condition? _______ If yes, please explain:
   ____
2. Do you see a chiropractor? _______ If yes, how often? ____________________________

Please check any condition listed below that applies to you:

- ○ Contagious skin condition
- ○ Open sores or wounds
- ○ Easy bruising
- ○ Recent accident or injury
- ○ Recent fracture
- ○ Recent surgery
- ○ Artificial joint
  ____
- ○ Sprains/strains
- ○ Current fever
- ○ Insomnia
- ○ Allergies/sensitivity
- ○ Heart condition
- ○ High or low blood pressure
- ○ Circulatory disorder
- ○ Varicose veins
- ○ Arthritis
  Type
  ____
- ○ Osteoporosis
- ○ Epilepsy
- ○ Headaches/migraines
- ○ Cancer
- ○ Diabetes
- ○ Decreased sensation
- ○ Back/neck problems
- ○ Fibromyalgia
- ○ TMJ
- ○ Carpal tunnel syndrome
- ○ Tennis elbow
- ○ Pregnancy if yes, how many
  Months ________________

PRIMARY COMPLAINT



Reason for visit ____

When did symptoms appear? ____

Is condition getting progressively worse? ◊ YES ◊NO ◊Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe) ________

Please mark on picture at right to show where your discomfort is.

Type of pain: ◊Sharp ◊Dull ◊Throbbing ◊Numbness ◊Other_________

Time of day it is worse ◊AM ◊PM What % of day in pain ________________

Does it interfere with ◊Work ◊Sleep ◊Recreation ◊Daily Routine__________?

Is there anything you do that relieves the pain? _____________________________

What makes the symptoms worse? _____________________________________

Notes

____

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Consent for Care

Draping will be used during the session – only the area being worked on will be uncovered.

Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

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 therapist are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during 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 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.

Approval of Patient____ **Date** _______________________

Approval of Massage Therapist______________________________________ **Date** _________________