

# MISSION WELLNESS

## CHIROPRACTIC

ACUPUNCTURE ♦ MASSAGE THERAPY

### Massage Intake Form

You are about to experience the many benefits of a therapeutic massage. To assist us in providing you with the best possible massage experience, please take a few minutes to complete the following questions. The information you provide is strictly confidential and will be used to tailor your massage to your individual needs. Please feel free to ask questions that you might have. Then just sit back, relax, and let us do all the work.

Name: \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Emergency contact \_\_\_\_\_

Profession: \_\_\_\_\_

If you answer "yes" to any of the following questions, please explain as clearly as possible.

- |   |  |
|---|--|
| Have you received a professional massage in the past?           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you currently under a physician and/or chiropractor's care? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you being treated for depression/anxiety?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have diabetes?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any contagious disease?                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have osteoporosis?                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a circulatory problem?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any allergies?                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you been in an accident or injury?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you suffer from epilepsy or seizures?                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you bruise easily?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have tension or soreness in a specific area?             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have cardiac or circulatory problems?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you suffer from back pain?                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

### See Reverse

- |  |  |
|--|--|
| Are you very sensitive to touch or pressure in any area? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had surgery?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you pregnant?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any other medical condition?                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have high/low blood pressure?                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |

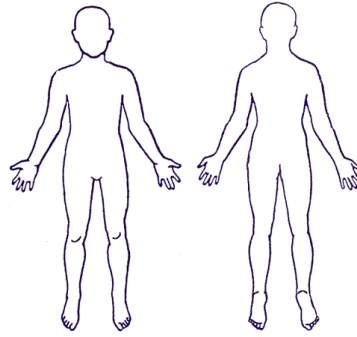
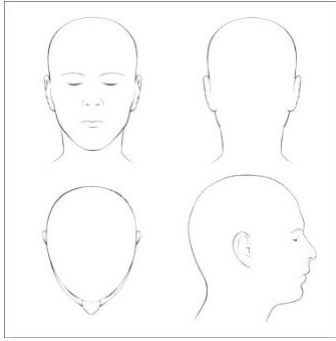
Are you taking medication? (list below)

Yes  No

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Please mark any current problem areas below: (pain, tension, stiffness limited movement)



Comments:

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I have provided the above information to the best of my knowledge. I understand that therapeutic massage services are designed to be a health aid and are in no way a replacement for medical care. Information exchanged with the massage therapist is educational and intended to help them become more familiar with your health status and is to be used at my discretion. If I feel any discomfort during my sessions, I will notify the therapist immediately. Any illicit or sexually suggestive remarks or advances, made by me, will result in immediate termination of the session. ***I will honor my appointments and I agree to cancel 24 hours in advance. I agree to pay the full fee for any appointment missed without 24 hours' notice.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_