Massage Therapy Intake Form

Active Chiropractic & Physical Therapy
101 S. Tracy Blvd.;Tracy, CA 95376
Tel: (209) 830-8855; Fax: (209) 830-8837

Name:_____ Date:_____ Birth:_____
Home Phone: ( )_____Work Phone: ( )_____Cell Phone: ( )_____
E-mail address:_____
Address:_____City:_____St:_____Zip: _____
Referred by:_____ Have you ever had a professional massage before?_____
If so, how often_____ Do you exercise? _____Frequency:_____
Please describe what type of
exercise_____
Other daily activities:_____
Occupation:_____
Primary Care Physician:_____
Chiropractor:_____
How do you relieve stress or
pain?_____
What are the reasons for your visit today?
_____
What are your other health concerns?
_____
Describe any surgeries you have had: _____
Describe any accidents you have had: _____
List all conditions currently monitored by a Health Care Provider: _____
List any medications that you took today: _____

Please note all current and previous conditions:

Headache Y /N
Sleep Problems Y /N
Fatigue Y /N
Flu or cold symptoms in the last 48 hours Y N
Sinus Y /N
Allergies to scents or lotions Y /N
Allergies, in general Y/ N
Arthritis Y /N
Osteoporosis Y /N
Scoliosis Y/ N
Broken bones Y/ N
Disc problems Y/N
Spasms/cramps Y /N
TMJ (jaw pain) Y/N
Tendonitis/bursitis Y/N
Spinal Problems Y/N
Varicose Veins Y/N

Stiff/painful joints Y/N
Neck, shoulder, or arm pain or Numbness Y/N
Low back, hip or leg pain or numbness Y/N
Sciatica Y/N
Depression Y/N
Blood clots Y/N
Stroke Y/N
Heart disease Y/N
High/low blood pressure Y/N
Poor circulation Y/N
Asthma Y/N
Thyroid dysfunction Y/N
Diabetes Y/N
Currently pregnant Y/N
Malignant cancer or tumors Y/N
Benign cancer or tumors Y/N

Describe, as needed, any conditions indicated above, or other conditions that you feel may be important
Contract for care:

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I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my Massage Therapist and other members of my health care team. I agree to participate in the self-care program that we select. I promise to inform my health care team any time I feel my well-being is threatened or compromised. I expect my Massage Therapist to provide safe and effective treatment.

Consent for care:

It is my choice to receive massage therapy, and I give consent to receive treatment. I understand that Massage Therapists DO NOT diagnose illness, disease or any other physical or mental disorders. Massage therapy is not a substitute for medical examination and/or diagnosis. I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my physical/mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so.

Signature:_____Date:_____

Signature of
parent/guardian:_____Date:_____
(if patient is a minor)

If you are unable to keep your appointment, please give 24 hours notice.

CASH TIPS ONLY