# Scheetz Chiropractic

Massage Therapy Client Intake Form

Name: ______________________________________________ Date: _____________________________

Address: ______________________________ City: _______________ Zip: __________________________

Home Phone: __________________________ Cell/Work Phone: ____________________________________

Date of Birth: ______________________ Occupation:_______________________________________________

Email: ____________________________ Referred by: ______________________________________________

Are you currently a patient of Scheetz Chiropractic? Yes / No

Previous experience with massage: _____________________________________________________________

___________________________________________________________________________________________

Primary reason for appointment/areas of pain or tension: _______________________________________________

___________________________________________________________________________________________

Emergency contact (name and number): __________________________________________________________

**Please mark (X) for all conditions that applies now, (P) for past conditions, and an (F) for family history of illness.**

**Pain Scale: minor-1 2 3 4 5 6 7 8 9 10-severe**

____ headaches, migraines
____ vision problems, contact lenses
____ hearing problems, deafness
____ injuries to face or head
____ sinus problems
____ dental bridges, braces
____ jaw pain, TMJ problems
____ asthma or lung conditions
____ constipation, diarrhea
____ hernia
____ high/low blood pressure
____ abdominal/digestive problems

____ chronic pain
____ muscle or joint pain
____ muscle, bone injuries
____ numbness or tingling
____ sprains, strains
____ arthritis, tendonitis
____ cancer, tumors
____ spinal column disorders
____ diabetes
____ pregnancy
____ heart, circulatory problems
____ other medical conditions not listed

____ fatigue
____ tension, stress
____ depression
____ sleep difficulties
____ allergies, sensitivities
____ rashes, athlete's foot
____ infectious disease
____ blood clots
____ varicose veins
____ birth control, IUD
____ STD(s)

Explain any areas noted above: _________________________________________________________________

___________________________________________________________________________________________

Current medications (including aspirin, ibuprofen, herbs, supplements, etc.): ________________________________

___________________________________________________________________________________________

Surgeries: ________________________________________________________________Dates:_________________

Accidents: ________________________________________________________________Dates:_________________

Please list all forms and frequency of stress reduction activities, hobbies, exercise or sports participation:

___________________________________________________________________________________________

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## Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing, and reduce muscular tension, it is not a substitute for medical examination, diagnosis, and treatment.
2. 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.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: ______________________________________________ Date ______________

Consent to Treatment of Minor: By my signature below, I hereby authorize *Lynelle Robieson, L.M.T.* to administer massage therapy techniques to my child or dependent as she deems necessary.

Signature of Parent or Guardian: ____________________________ Date ______________