

KAISER CHIROPRACTIC, S.C. MASSAGE INTAKE FORM

PATIENT INFORMATION				
Name:		Birth Date:		
Address:		Phone:		
City:	State:	Zip:		
E-mail:				
Occupation:				
In case of an emergency, please contact:		Phone:		
Who can we thank for referring you to our office: Phonebook Website Sign Referral Other				
MASSAGE HISTORY/INFORMATION				
Have you ever received a professional massage? Y N Date of last massage:/				
My goal for my massage today is :				
□ To relax	□ To get work on a sp	☐ To get work on a specific area		
□ To help relieve a health concern □ To experience a therapeutic massage				
□ Other:				
I feel the pressure that would best fit my needs would be:				
□ Very light/light □ Medium □ Deep/Heavy □ I don't know *The therapist always works within your tolerance level, do not hesitate to let her know if the pressure is/isn't correct for you.				
Please indicate any area of tension or soreness that you would like to massage therapist to address specifically. Please circle or "X" the area to the left. Prioritize ONLY specific problem areas: NeckUpper BackHipLegsLower BackArmsHandsUpper ChestFeetFace/Scalp (1-High Priority, 2-Secondary, 3– If we have time)				

ABOUT YOUR HEALTH

The human body is designed to be healthy. I am dedicated toward achieving the goal of optimal and lasting health for my clients. To better help achieve this, I need to understand your complete health history.

Please take a few moments to answer the following questions.

	HEALTH CONDITIONS		
Please CHECK any of the following that you currently have or CIRCLE if you have had in the past.			
MUSCULOSKELETAL	CIRCULATORY	RESPIRATORY	
□ Spinal Problems	☐ Heart Condition	□ Breathing Difficulty/Asthma	
☐ Tendonitis/Bursitis	□ Phlebitis/Varicose Veins	□ Emphysema	
□ Arthritis/Gout	☐ High/Low Blood Pressure	☐ Sinus Problems	
□ Other:	□ Other:	□ Other:	
SKIN	NERVOUS SYSTEM	OTHER	
☐ Rashes	☐ Shingles	☐ Chronic fatigue	
☐ Allergies	☐ Numbness/Tingling	☐ Sleep disorders	
☐ Other:	□ Other:	☐ Migraines/Headaches	
DIGESTIVE	REPRODUCTIVE	☐ Chronic pain	
☐ Irritable Bowel Syndrome	□ Prostate	☐ Anxiety/Stress/Depression	
□ Ulcers	☐ Pregnant: Stage	☐ Diabetes	
☐ Other:	☐ Other:	☐ Cancer/Tumors	
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Please list all medications that you are currently taking and what they are for.			
INFORMED CONSENT			
I understand that massage therapy provided by, Kaiser Chiropractic, S.C., is not a replacement for chiropractic or			
medical care, and that she does not diagnose illness or disease, does not prescribe medications, and that spinal			
adjustments are not part of massage therapy. I have informed them of all my known physical conditions, medical conditions and medications, and I will keep Kaiser Chiropractic, S.C., updated on any changes.			
Patient Signature			