

# Healing Lakes Chiropractic Massage Client Intake Form

Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone Number \_\_\_\_\_

Date of initial visit \_\_\_\_\_

Please carefully read the following information and sign where indicated. Massage/bodywork may be harmful to you if you have a specific illness. A referral from your Physician may be required prior to service being provided.

1. Have you had a massage before? If so, what kind? \_\_\_\_\_

2. What are your goals for today's massage therapy session? \_\_\_\_\_  
\_\_\_\_\_

3. What physical activities do you do during the week and are there any specific areas that I need to focus on? \_\_\_\_\_  
\_\_\_\_\_

4. Do you have any prior injuries that I need to know about? \_\_\_\_\_  
\_\_\_\_\_

5. Do you have any allergies or hypersensitivities? \_\_\_\_\_  
\_\_\_\_\_

6. List any major accidents and surgeries:  
\_\_\_\_\_  
\_\_\_\_\_

## HEAD NECK

Headaches/migraines

Hearing loss

Vertigo/dizziness

Vision problems

Ringing in ears

Vision loss

**RESPIRATORY**

- Asthma
- Shortness of breath
- Chronic cough
- Bronchitis
- Emphysema
- Sinusitis
- Frequent colds
- Smoker
- Frequent history of respiratory difficulties

**NERVOUS SYSTEM**

- Sensory loss/change
- Numbness/tingling
- Sciatica
- Epilepsy
- Seizures
- Multiple sclerosis

**MUSCULOSKELETAL SYSTEM**

- Arthritis
- Family history of arthritis
- Osteoporosis
- Tendonitis
- Bursitis
- Jaw pain (TMJ)
- Pins/plates/wires/artificial joints

**REPRODUCTIVE**

- Pregnant (Due \_\_\_\_\_)
- Given birth
- Gynecological problems

**CARDIOVASCULAR**

- High blood pressure
- Low blood pressure
- Heart attack
- Stroke
- Heart disease
- Poor circulation
- Phlebitis/varicose veins
- Pacemaker
- Hemophilia
- Chronic congestive heart failure
- Family history of cardiovascular problems

**OTHER CONDITIONS**

- Cancer     Diabetes
  - Unexplained weight loss
  - Fibromyalgia
  - Chronic fatigue syndrome
  - Depression     Digestive conditions
  - Anxiety     Psychiatric disorder
  - Other \_\_\_\_\_
-

**PLEASE READ CAREFULLY**

I understand that massage/bodywork is for relaxation and muscle tension relief. If I experience any pain or discomfort during this or any session, I will immediately inform the practitioner so the strokes or pressure can be adjusted. I further understand that massage or bodywork should not be construed as a substitute from medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/body work should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all the questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. \*\*\*I also understand that sexual harassment will end in termination of my massage.\*\*\*

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

Practitioner signature \_\_\_\_\_

**Consent to Treatment of Minor:** By my signature below, I hereby authorize \_\_\_\_\_ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Cancelation and No Show Policy**

A **\$50 fee** will be charged to your account for any visits that were not canceled **prior to 12 hours** before your appointment.

Please **initial** that you have read and understand this policy \_\_\_\_\_