Complete Chiropractic and Bodywork Therapy
Massage/Bodywork Intake Form

Client Information:

Name:_____

Gender: *Male* *Female* *Other* *Not Specified*

Date of Birth: _____

Contact Information:

Preferred Phone Number:_____

Secondary Phone Number:_____

E-Mail:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Emergency Contact Information:

Emergency Contact Name:_____

Emergency Contact Phone Number:_____

Contact Relationship to Client:_____

Physician Information:

Name of Primary Care Physician:_____

Phone Number of Physician:_____

Name of Chiropractic Physician:_____

Phone Number of Chiropractor (if not CCBT):_____

Reason for Visit (i.e. relaxation, injury, issue):

If injury or issue, how long has it been present?

Have you had past treatment for this injury/issue? If so, please explain.

What is your desired outcome of today's visit?
(i.e. Relaxation, recovery of range of motion, ease of specific pain)

Medical Checklist:
Please check any of the following as they apply to you:

Cardiovascular:

__ Blood Clots	__Cardiovascular Accident	__Stroke	__Thrombosis/ Embolism
__Cold Hands	__Congestive Heart Failure	__Pacemaker	__Varicose Veins
__Cold Feet	__Low Blood Pressure	__Heart Attack	__Lymphedema
__Phlebitis	__High Blood Pressure	__Heart Disease	

Respiratory:

__Asthma	__Emphysema/COPD	__Chronic Cough	__Shortness of Breath

Skin:

__Shingles	__Hypersensitivity	__Melanoma	__Skin Irritations

Women:

	__Current Pregnancy

Neurological:

__Tingling	__Multiple Sclerosis	__Dizziness	__Stabbing Pain
__Burning	__Cerebral Palsy	__Herniated Disc	__Loss of Sensation
__Numbness	__Parkinson's Disease	__Epilepsy	__Seizures

Soft Tissue / Joint Dysfunction:

		__Upper back (left)	__Upper back (right)
__Ankle (left)	__Ankle (right)	__Arm (left)	__Arm (right)
__Foot (left)	__Foot (right)	__Lower leg (left)	__Lower leg (right)
__Hand (left)	__Hand (right)	__Hip (left)	__Hip (right)
__Knee (left)	__Knee (right)	__Lower back(left)	__Lower back (right)
__Mid back (left)	__Mid back (right)	__Neck (left)	__Neck (right)
__Shoulder (left)	__Shoulder (right)	__Thigh (left)	__Thigh (right)

Head & Neck:

__Headaches	__Sinus Problems	__Vision Loss	__Jaw Pain (TMJD)
__Migraines	__Vision Problems	__Hearing Loss	__Ear Problems

Miscellaneous:

__Allergies	__Anaphylaxis	__Arthritis	__Cancer
__Crohn's Disease	__Artificial Joints/Equipment	__Diabetes	__Digestive Conditions
__Gout	__Hemophilia	__Insomnia	__Fibromyalgia
__Lupus	__Osteoporosis	__Mental Illness	__Surgical pins or wires
__Stress	__Rheumatoid Arthritis	__Osteoarthritis	__Bruise Easily

Please list any other medical conditions or diagnoses not covered under the previous checklist:

Please list any medications you are currently taking (or provide a list for us to copy):

Somatic History:
In support of your care, we ask you to share any history that may affect how you respond to touch. This may include, but is not limited to, traumatic experiences or histories, mental health and/or physical issues. Relevant information may be written here or shared verbally with your care provider. As always, all information shared with your care provider is confidential.

Client Waiver:

- *I understand that massage is entirely therapeutic and non-sexual in nature. If there are any sexual suggestions or advances, the massage session will be ended immediately with payment due for the entire scheduled session.*

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that the pressure/strokes can be adjusted to my level of comfort.
- I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform my therapist of any changes in my health and medical condition. I understand there shall be no liability on the therapist's part should I forget to do so.

I have read and agree to these policies.

Client Signature: _____ Date:_____