BRADFORD FAMILY CHIROPRACTIC

MASSAGE & SPORTS REHAB

MASSAGE THERAPY INTAKE

Name: _____ Date: _____

Address: _____City: _____

State: _____ Zip Code: _____ Cell Phone: _____

Other Phone & Type: _____ Date of Birth: _____

Email: _____ Gender: _____

Married___ Single____ Widowed ____ Divorced___ Occupation: _____

Referred to this office by: _____

Appointment Reminders-24 HRS before: Email Text Call (Circle Preferred Method)

HEALTH & MEDICAL HISTORY

Are you currently under the care of a health practitioner? _____ If yes, specify purpose _____

Current Medications and Purpose _____

_____

Allergies: _____

MARK ANY OF THE FOLLOWING CONDITIONS IF NOW OR PREVIOUSLY HAVE HAD

Musculoskeletal

- ☐ Bone or joint disease
- ☐ Tendonitis/Bursitis
- ☐ Arthritis/Gout
- ☐ Jaw Pain (TMJ)
- ☐ Lupus
- ☐ Spinal Problems

Respiratory

- ☐ Asthma/Breathing Difficulty
- ☐ Emphysema
- ☐ Sinus issues

Skin

- ☐ Rashes
- ☐ Herpes/Cold sores

Nervous System

- ☐ Shingles
- ☐ Pinched Nerve
- ☐ Numbness/Tingling

Circulatory

- ☐ Heart Condition
- ☐ Phlebitis/Varicose Veins
- ☐ Blood Clots
- ☐ High/Low Blood Pressure
- ☐ Lymphedema
- ☐ Thrombosis/Embolism

Other

- ☐ Ovarian/menstrual problems
- ☐ Prostate
- ☐ Bladder/Kidney
- ☐ Depression
- ☐ Anxiety
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Cancer/tumors
- ☐ Diabetes
- ☐ Irritable bowel syndrome

Are you currently pregnant? If yes what stage:

_____

Surgeries/Injuries/Accidents?

_____

_____

_____

_____

_____

Additional comments/remarks related to any health & medical history

_____

_____

_____

_____

_____

_____

MASSAGE THERAPY INTAKE CONTINUED

Have you ever received a professional massage? _____ Date of last massage_____

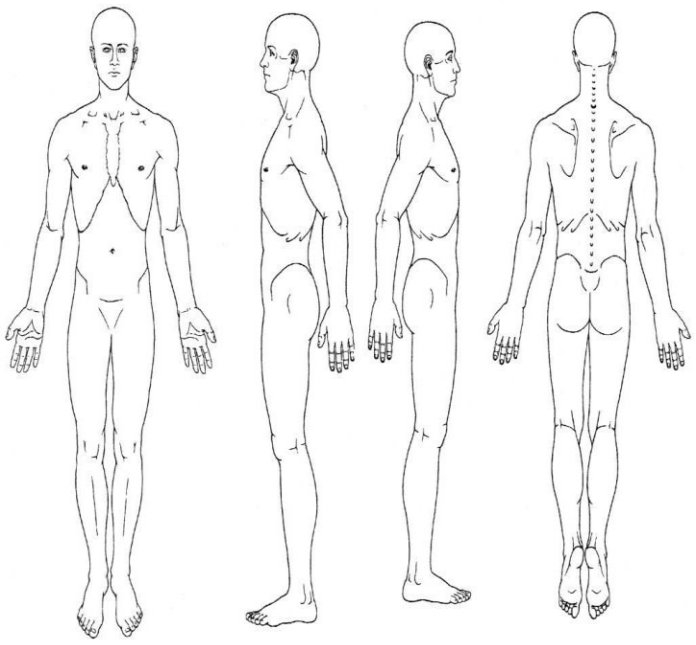
What result do you want from your massage session?

_____

Is there any areas you DO NOT want massaged?

_____

PLEASE INDICATE FOCUS AREAS



I have completed this form to the best of my knowledge and will inform the massage therapist any change in physical health. I understand that a massage therapist can not diagnose illness, disease, or any other medical, physical, or emotional disorder, nor perform any spinal manipulations. I am responsible for consulting a qualified physical for any physical ailments that I have. I understand massage therapy is a therapeutic health aide and is non-sexual. I understand that if the massage therapist starts a session late, they will make it up to me at the end of my session late or reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following is not penalized. I agree to give 24- hour notice for a scheduled session that I can not keep. **If an appointment is cancelled less than the 24 hour notice I agree to paying a $20 fee. All missed appointments are charged full priced. Gratuity is encouraged but not required.**

Client Printed Name: _____ Client Signature: _____

Date: _____ If a minor, Printed name of Client Parent/Guardian_____

Relationship to client? _____ Signature: _____

IF A MINOR A PARENT OR A GUARDIAN MUST PRESENT DURING THE SESSION.