Chester Family Chiropractic Center
Massage Intake

Personal Information

First Name: _____ Last Name: _____ DOB: _____

Email: _____ Primary Doctor at CFCC: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list names and how administered: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Bulging/herniated disk
- ☐ Arthritis
- ☐ Diabetes
- ☐ Surgeries
- ☐ Bruise easily
- ☐ Neuropathy
- ☐ Infection
- ☐ Stroke
- ☐ Heart Attack
- ☐ Seizures
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation/Self-Care ☐ Therapeutic/Palliative/ Health Care

Other _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

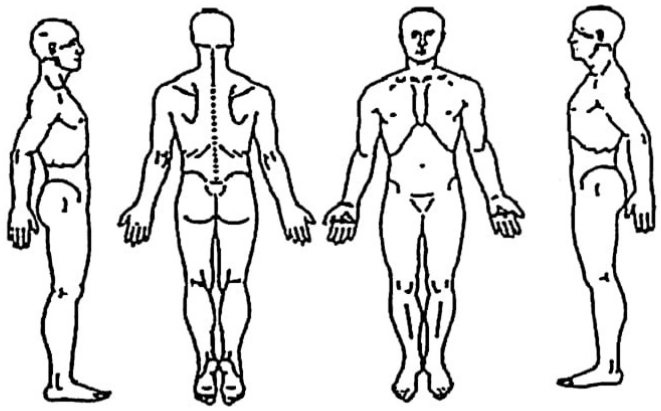
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____

Consent Form

I have been advised of the policies and procedures pertaining to massage and I understand these policies. The massage procedures, information about massage in general, benefits and contraindications of massage, and possible alternative therapies have been explained to me.

I understand that the massage I receive is for the purpose of stress reduction and/or relief of muscular tension, spasm, or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform the therapist so that pressure or methods used can be adjusted to my comfort level. I understand that massage therapist do not diagnose illness or disease, nor do they perform spinal manipulations or prescribe any medical treatments, and nothing said or done during the session should be construed as such.

I acknowledge that massage is not a substitute for medical examination/diagnosis, and I should see a health care provider for those services. Because massage should not be performed under certain circumstances, I agree to keep the massage therapist updated as my health may change

Print Name: _____ Signature: _____

Date: _____