Client Information for Massage Therapy – Northern Chiropractic

Client Name:____ Birth Date:__________________
Last First MI
___M ___F ___Married ___Single ___Child

Phone: (Home):________________ (Work):________________ Ext.______ (Other):________________

Address:____
Street City State Zip Code

Emergency contact person:____ Phone:________________

Employment Information

The following is for: ___the client ___the person responsible for payment

Employer Name:___________________________________ Occupation:____________________________

Address:____
Street City State Zip Code

Health Information

Have you ever had any of the following? Please check all that apply:

___ AIDS
___ Stroke
___ Mental Disorders
___ Arthritis
___ Venereal Disease
___ Codeine Allergy
___ Radiation Tx.
___ Heart Murmur
___Hepatitis
___ Dizziness
___ Epilepsy
___ Rheumatism

___ Excessive Bleeding
___ Allergies
___ Tuberculosis
___ Hay Fever
___ Artificial Joint
___ Asthma
___ Penicillin Allergy
___ Cancer
___ Diabetes
___ Jaundice
___ Kidney Disease
___ CURRENT MEDICATIONS: ______________________________
____
___ Other: ____

___ Liver Disease
___ Fainting
___ Anemia
___ **Pregnancy: due date** _______
___ Head Injuries
___ Heart Disease
___ Blood Disease
___ Respiratory Problems
___ High Blood Pressure
___ Sinus Problems
___ Stomach Problems

- Have you been admitted to a hospital or needed emergency care during the past two years?
___Yes ___No

If yes, please explain: ____
- Are you now under the care of a physician? ___Yes ___No

If yes, please explain: ____
- Name of Physician: ____
- Do you have any health problems that need further clarification? ___Yes ___No

If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the therapist at the next appointment without fail.

______________________________ ____________
Signature of patient, patent or guardian Date

______________________________ ____________
Therapist signature Date

Please complete the front and back of this form. Thank You!!

Massage Intake, continued

What is your major concern for today?_______________________________ other areas:_______________

How would you describe your discomfort?____

Intensity: ___Mild ___Moderate ___Severe ___Other:____

Duration: ___Constant ___Intermittent ___With certain motions___________________________________

How long does the discomfort last when it occurs? ___Minutes ___Hours ___Days

How long has this discomfort been present?____

What activities are difficult/painful to do?____

What activities are helpful to do?____

What are the most frequent activities you're involved in at work and home?

___Sitting ___Standing ___Lifting ___Other____

In which part of your body do you feel stress most often? Check all that apply:

___Head ___Neck ___Shoulders ___Back ___Extremities ___Other:_______________________

Is a portion of your day set aside for relaxation? ___Yes ___No If yes, what kind?___________________

Previous injuries, including broken bones, NOT requiring surgery:__________________________________

____

Previous surgeries with approximate dates:____

____

Mark the areas, on the figures below, where you are feeling discomfort.

Label the area(s) of discomfort using arrows and other descriptions as needed:

Pain: XXX
Numb: NNN
Burn: BBB
Spasm: SSS
Tingly: TTT

Comments/descriptions:______________________

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____

____

____

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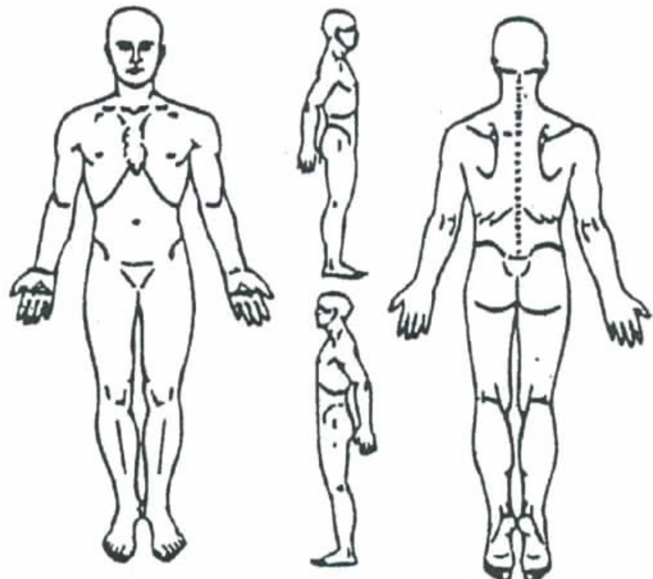

Consent for Massage Therapy
Northern Chiropractic

- The unclothed body will be properly draped at all times for your sense of security and as a mark of massage professionalism.
- Focused attention & manual therapy will be given as agreed upon by the therapist and patient for the predetermined goal of health protection.
- My therapist has discussed the potential benefits and any side effects of this therapy. I have been given the opportunity to ask questions.
- I, as patient, agree to provide complete and accurate health information and notice of health changes at successive points.
- I understand that therapeutic massage is designed to be an ancillary health aid and is not suitable for primary medical treatment.
- I will immediately inform my therapist of any unusual sensations or discomfort, so that the application of pressure or strokes may be adjusted to my comfort level.
- I understand that this is a therapeutic massage and is performed by a trained, state-licensed therapist.
- I understand that the massage is not sexually oriented and that any illicit behavior on my part will result in immediate termination of the session and all other future appointments.
- I understand that by signing this form, I give my consent to receive the treatment discussed in this and all future sessions. I agree that my presence at subsequent sessions shall be construed to be validation of this written consent.
- I have read this from and hereby give my permission to be treated with massage therapy.
- Cancellation notice is required 24hrs. in advance.
- A second and/or third no show appointment will result in being placed on a 'walk-in status' of scheduling.

Date:___/___/_____ Signature:________________________________