

# Sunset Hills Chiropractic • Freedom Chiropractic

## Massage Intake Paperwork

### Client Medical History

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Have you Ever received a professional Massage:  Yes  No Last treatment: \_\_\_\_\_

What type of touch do you prefer?  Light/Medium  Medium/Deep  Deep/Trigger Point

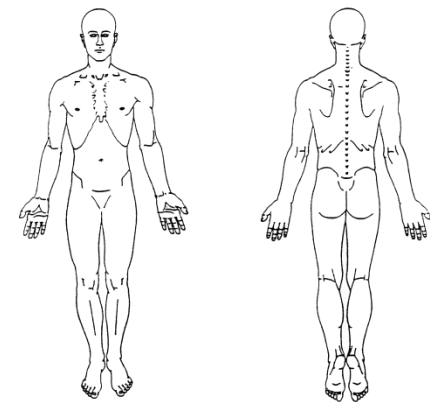
### Do you have any of the following?

- |  |   |                                     |
|--|---|-------------------------------------|
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Pregnancy  |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Stomach Ulcers           | <input type="checkbox"/> Headaches  |
| <input type="checkbox"/> Varicose Veins          | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Hernia     |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> Cancer     |
| <input type="checkbox"/> Skin Conditions         | <input type="checkbox"/> Easily Bruised           | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Phlebitis  |
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Musculoskeletal Problems |                                     |

Are there any other Health Conditions we should be aware of?  Yes  No

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_



Please mark on the chart your areas of discomfort.

What is your major complaint? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I understand that the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension or spasm, and/or improving circulation. I understand that a massage therapist neither diagnoses illness, disease, or any other medical, physical, or mental disorders – nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailment I may have.

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