Schmidt Chiropractic Center

Massage Therapy Client Intake Form

Please take a moment to fill out the following information, the information provided will be used to customize your session to your wants and needs, allowing modalities to be excluded that will be medically unfit for your safety.

Name:_____ **Date of Birth:**_____**Male/Female**

Address:_____**City/State/Zip:**_____

Phone:_____**(H/C/W) Occupation:**_____

Emergency Contact:_____ **Phone:**_____

Please answer the following to the best of your ability.

Have you experienced a professional massage before? Y N If yes, when?_____

What are your goals for your session today?_____

Please list all sports, activities, and hobbies:_____

Do you have any allergies (i.e.: oils, nuts, etc.):_____

Current Medications/OTC Drugs/Herbs/Supplements:_____

_____

Please list all accidents, injuries, and surgeries and dates:_____

_____

Please check any condition/symptom that applies to you, past or present.

Musculoskeletal System	**Nervous System**	**Circulatory System**
__ Joint Replacement	__ Alzheimer's	__ Blood Clots/Embolism
__ Fibromyalgia	__ Herpes Zoster/Shingles	__Congestive Heart Failure
__ Muscular Dystrophy	__ Multiple Sclerosis	__ Heart Attack
__ Osteoarthritis	__ Parkinson's Disease	__ High/Low Blood Pressure
__ Osteoporosis	__Peripherial Neuropathy	__ Leukemia
__ Plantar Fasciitis	__Seizures/Epilepsy	__ Stroke/TIA
__ Rheumatoid Arthritis	__ Numbness/Tingling	__Varicose Veins
__ Other:_____	__ Other:_____	__Other:_____

Lymph/Immune System	**Skin**	**Miscellaneous**
__ Allergies	__ Dermatitis	__ Cancer
__ Autoimmune Disorder	__ Eczema	__ Diabetes
__ Chronic Fatigue	__ Psoriasis	__ Easy Bruising
__ Lupus	__ Other:_____	__ Headaches/Migraines
__ Lymphoma		__ Other:_____
__ Other:_____		__ Pregnant: Due Date:_____

I understand the massage therapy I receive at this clinic is intended for general wellness purposes, including pain reduction and management, the promotion of circulation, increased flexibility, and decreased stress. I understand that massage therapists do not diagnose illness, disease, or any other physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals, including performing spinal manipulations. I understand that I should seek out an appropriate health care provider for diagnosis or treatment of any suspected medical problems. I understand that it is my responsibility to inform my therapist of any existing medical conditions I currently have, and keep my therapist updated to changes to my health or medications in the future. I understand that if these changes are significant enough, they may warrant a new intake to be filled out. I understand that if I fail to do so, there shall be no liability on my massage therapist's part. If I experience pain or discomfort during the session, I will immediately inform my massage therapist so that the pressure and/or modality may be adjusted to my level of comfort. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in an immediate termination of the session, and I will be liable for payment of the scheduled appointment. I also understand that I may be turned away if I appear to be under the influence of drugs or alcohol.

Client Signature:_____ **Date:**_____

Cancellation Policy

All cancellations must be made 24-hours in advance. I understand that if I do not give a 24-hour notice for cancellation or are a no-show, I am responsible for the payment of the scheduled appointment and my account will be billed. I agree to these terms and conditions.

Client Signature:_____ **Date:**_____

Office Use:

Practitioner Signature:_____ **Date:**_____