Ash Chiropractic & Acupuncture Clinic

Ashraf A. Soomar-Kheraj, B.S., D.C.

THERAPEUTIC MASSAGE INTAKE FORM

Patient Name: _____ Date of Birth: _____ Gender: ____ Date: _____

Occupation: _____ Have you ever received a professional massage? _____

List known allergies or sensitivities: _____

Check (√) any or all that apply to your present health:

□ Headaches	□ Scoliosis	□ Skin problems
□ Chronic pain	□ Cancer/tumors	□ Sinus problems
□ Varicose veins	□ Arthritis	□ Diabetes
□ Blood clots	□ Infectious disease	□ Numbness/tingling
□ Vision problems	□ Tendonitis	□ Depression
□ Muscle/Joint pain	□ Prostate problems	□ Painful menses
□ Jaw pain/teeth grinding	□ Endometriosis	□ Sleep difficulties
□ Sprains/strains	□ Fatigue	□ High/low blood pressure

Check (√) the appropriate areas of concern:

□ Head & neck	□ Hips & Thighs	□ Hands & Wrists
□ Upper back	□ Knees & Legs	□ Other areas (Please explain)
□ Mid-back	□ Feet & Ankles	_____
□ Low back	□ Shoulders & arms	_____

Remarks: _____

_____

_____

By signing this consent form, I understand a massage therapist CANNOT diagnose illness, disease or any other medical, physical or emotional disorder, nor perform spinal manipulation. It is my responsibility to consult a qualified physician for medical advice and/or treatment. I understand that massage therapy is a health-aide only.

Patient Signature: _____ Date: _____ Patient No: _____

4300 North Josey Lane Suite 104 · Carrollton, TX 75010 · Phone (972) 317-0680 · Fax (972) 317-0690

Email: Dr.Ash@AshChiro.com · www.AshChiro.com