



# Ash Chiropractic & Acupuncture Clinic

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## 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 (v) any or all that apply to your present health:**

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

**Check (v) the appropriate areas of concern:**

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> Head & neck | <input type="checkbox"/> Hips & Thighs    | <input type="checkbox"/> Hands & Wrists               |
| <input type="checkbox"/> Upper back  | <input type="checkbox"/> Knees & Legs     | <input type="checkbox"/> Other areas (Please explain) |
| <input type="checkbox"/> Mid-back    | <input type="checkbox"/> Feet & Ankles    | _____   |
| <input type="checkbox"/> Low back    | <input type="checkbox"/> 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: \_\_\_\_\_

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