

Entered \_\_\_\_\_

\_\_\_\_\_  
 Last name First name

**Goble Heal Chiropractic Massage Intake**

\_\_\_\_\_  
 Home Phone Cell Phone Social Security # Date of Birth

**The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.**

- Date of Initial Visit \_\_\_\_\_
1. Have you had a professional massage before?  
 Yes No  
 If yes, how often do you receive massage therapy?  
 \_\_\_\_\_
  2. Do you have any difficulty lying on your front, back or side? Yes No  
 If yes, explain \_\_\_\_\_
  3. Do you have any allergies to oils, lotions or ointments? Yes No  
 If yes, explain \_\_\_\_\_
  4. Do you have sensitive skin? Yes No
  5. Are you wearing contact lenses( )dentures ( )a hearing aid( )?
  6. Do you sit for long hours at a workstation, computer, or driving? Yes No
  7. Do you perform any repetitive movement in your

- work, sports or hobby? Yes No  
 If yes, describe \_\_\_\_\_
8. How has stress affected your health? Muscle tension( ) Anxiety( ) Insomnia( ) Irritability( )  
 other \_\_\_\_\_
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No  
 If yes, identify \_\_\_\_\_
10. Do you have any particular goals in mind for this massage session? Yes No  
 If yes, explain \_\_\_\_\_  
 Are you currently under medical supervision?  
 Yes No  
 If yes, explain \_\_\_\_\_
11. Do you see a chiropractor? Yes No  
 If yes, how often? \_\_\_\_\_
12. Are you currently taking any medication? Yes No  
 If yes, list \_\_\_\_\_

**List any specific areas you would like the massage therapist to concentrate on during the session:**

\_\_\_\_\_

**Massage Therapist notes:**

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

**Diagnosis:** \_\_\_\_\_  
 \_\_\_\_\_

Please check any condition listed below that applies to you:

- contagious skin condition
- open sores or wounds
- easy bruising
- recent accident or injury
- recent fracture
- recent surgery
- artificial joint
- sprains/strains
- current fever
- swollen glands
- allergies/sensitivity
- heart condition
- high or low blood pressure
- circulatory disorder
- varicose veins
- atherosclerosis
- phlebitis
- deep vein thrombosis/blood clots
- joint disorder/rheumatoid
- arthritis/osteoarthritis/tendonitis
- osteoporosis
- headaches/migraines
- cancer
- diabetes
- decreased sensation
- back/neck problems
- fibromyalgia
- TMJ
- carpal tunnel syndrome
- tennis elbow
- pregnancy If yes, how many months
- epilepsy

Please explain any condition that you have marked above

\_\_\_\_\_

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

\_\_\_\_\_

Draping will be used during the session- only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, \_\_\_\_\_ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client \_\_\_\_\_ Date \_\_\_\_\_

**Options**

- 15 minute chair massage
- 30 minute deep tissue
- 90 minute therapeutic
- Neuro-muscular massage
- 60 minute relaxation
- Hot stone 90 minute therapeutic
- 30 minute relaxation
- 60 minute deep tissue
- Detox massage