Arctic Chiropractic
Massage Therapy Intake Form

Thank you for your interest in massage and body work. Please fill out the information and give your completed form to the receptionist.

Name:_____ Date:_____

Birth Date:_____

Weight:_____(lb) Height:_____(ft)

Address:_____

_____ Phone #:_____

_____

Occupation:_____

Referred By: _____

Please Review Any Illness and/or Medical Conditions (circle all that apply)

Diabetes	Contact lenses	Previous MVA/trauma	Rupture/bulging
Heart condition	Elevated cholesterol	Seizures	High blood pressure
Cancer	Varicose veins	Stroke	Phlebitis
Arthritis	Pins/needles	Autoimmune disease	Skin disorder
Scoliosis	Headache	Loss of balance	Infectious conditions
Painful joints	Fatigue/depression		

Other Conditions:_____

Are you currently pregnant? Y N If yes, how many months?_____

Please list any medicines you are currently taking: _____

Please list previous surgeries with approximate dates:_____

Describe your pain or discomfort

Are you experiencing any pain or discomfort? Y N If so where?_____

Intensity: *Mild* *Moderate* *Severe* *Other*
Duration: *Constant* *Intermittent* *With certain motions*

Frequent Activities at Work and Home (circle all that apply) *Sitting* *Standing* *Lifting* *Exercise*
Adequate Sleep: *Every Night* *Most Nights* *Difficulty sleeping* *Use a sleep aid*
Sleep Position: *Back* *Side* *Stomach* *Still* *Restless (Many positions)*

CLIENT INFORMATION AND RELEASE

Are you currently suffering from any ailment that could be negatively affected by today's massage? Y N
If yes, please explain:_____

_____

If yes, are you currently under a doctor's supervision for this ailment? _____Yes _____No

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CONSENT FOR THERAPY

- The unclothed body will be properly draped at all times for your warmth, sense of security, and a mark of massage professionalism.
- Focused attention and manual therapy will be given as agreed upon by therapist and client for the predetermined goals of stress reduction, relief of muscular discomfort, and/or health therapy. I have been given an opportunity to ask questions.
- I as a client agree to provide complete and accurate health information and notice of health changes at successive appointments as appropriate.
- I understand that massage therapy is designed to be an ancillary health aid and is not suitable primary health care treatment.
- Written referral is requested from your primary care provider if
    - You are currently receiving care or
    - You have a specific medical condition or symptoms for which you take medication or receive periodic evaluation or treatment.
- I will immediately inform my therapist of any unusual sensation or discomfort, so that the application of pressure or strokes may be adjusted to my level of comfort.
- I understand that this professional massage is therapeutic in nature and is performed by a trained state-licensed therapist.
- I understand that the massage is not sexually oriented in any way and that any illicit or suggested remarks or behavior on my part will result in immediate termination of the session.
- I understand that by signing this form, I give my consent to receive the treatment discussed in and all future sessions and agree that my presence at subsequent sessions shall be construed to validation of this written consent.
- **I have read this form and hereby freely give my permission to receive massage therapy.**

Date:_____ Printed Name:_____
(mm/dd/yyyy)

Signature:_____