Today's Date: _____ Patient Name: _____

MASSAGE INTAKE QUESTIONAIRE

Welcome and thank you for choosing **Crain Chiropractic & Wellness**. We will use the information you provide to determine how we can best help you. Please answer the best you can.

PERSONAL INFORMATION

First Name: _____Middle:_____ Last: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Date of Birth (M/D/Y): _____ Sex: **M F** Marital Status: **S M W D**

Email Address: _____

Preferred method of communication for patient reminders: **Email Phone Text**

Your Employer: _____ Occupation: _____

Name of Family Doctor: _____

Whom may we thank for referring you to our office? _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT

Name: _____ Relationship: _____

Phone: _____

CURRENT HEALTH CONCERN

Describe the primary reason for today's visit: _____

When did this start? _____

What do you feel caused this problem? _____

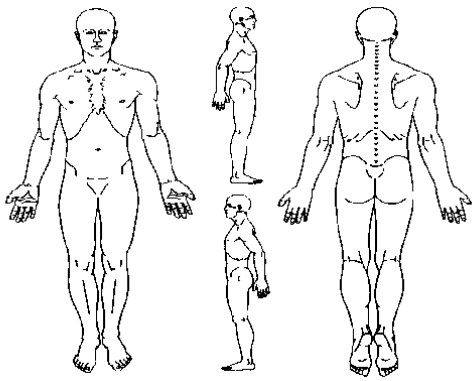
Pains are: **Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness**

Other: _____

On a scale of 0-10 please circle the number that represents your current pain level:

NORMAL	**0**		
LOW PAIN	**1**	**2**	**3**
MODERATE PAIN	**4**	**5**	**6**
INTENSE PAIN	**7**	**8**	**9**
EMERGENCY	**10**		

Please indicate where your pain is located:



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PAST HEALTH HISTORY

Have you ever had a professional massage? **Yes No** If so, how long ago? _____

Have you ever received chiropractic care? **Yes No** Approx. Date of last visit: _____

Chiropractor: _____

Are you pregnant? **Yes No** # Weeks: _____

Do you have any known allergies to lotions or oils? **Yes No** Please explain: _____

Have you ever sought treatment for any of the following?

___Headaches	___Carpal Tunnel	___Asthma	___Digestive Problems
___Neck Pain	___Vertigo	___Allergies	___Pain between Shoulder Blades
___Mid-Back Pain	___Low-Back Pain	___Loss of Balance	___Tension across Top of Shoulder
___Sciatic Pain	___Dizziness	___Menstrual Pain	___Numbness in Arms/Legs
___Leg/Hip Pain	___Fatigue	___Arm Pain	___Skin Problems
___Blood Clots	___Seizures	___Arthritis	___Circulation Issues
___Cancer	___Varicose Veins	___ Diabetes	___High/Low Blood Pressure

___Other_____

Have you ever sought the services for this or any other health concern from the following?

___Acupuncturist	___Naturopath	___Yoga	___Physical Therapist
___Personal Trainer	___Nutritionist	___Pilates	___Other_____

Are you currently taking any medications? *(Include regularly used over the counter medications)*

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

PERSONAL PREFERENCES

What kind of pressure do you prefer? **Light Medium Firm**

Level of conversation during your massage:

___I love to chat ___I prefer to lead the conversation ___I prefer silence

Today's Date: _____ Patient Name: _____

CONSENT TO TREATMENT

Please take a moment to carefully read the following information and sign where indicated:

- I, the undersigned, understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure/or strokes may be adjusted to my level of comfort. I have been informed that I may end the massage session with the therapist at any time for any reason.
- I further understand that massage/bodywork should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said during the course of the given session should be construed as such.
- Because massage/bodywork and body wraps should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly.
- The bodywork and massage technique which may be utilized during my session includes Swedish, Deep tissue, Trigger point, Stretching, Therapeutic, Prenatal, Hot Stone and Raindrop Therapy. The treatment does NOT include breast massage of the male or female client, nor will it include massage of the genitalia of either.
- I understand that draping is required throughout the service and is not optional. I also understand that if I make any illicit or sexually suggestive remarks or advances, it will result in immediate termination of the session, and I will be liable for full payment of my scheduled appointment.
- I relieve the massage therapist and Crain Chiropractic & Wellness from any liability resulting from an adverse reaction, injury or death due to any of the Spa or Massage services provided.
- We do not double book appointments. Your scheduled appointment has been set aside solely for you. We require 24 hours notice for cancellations and rescheduled appointments. We reserve the right to charge a missed appointment fee equivalent to the cost of your scheduled session.

I have read, understand and agree with the information provided above and will continue with the massage session accordingly.

Patient/Guardian Signature: _____ Date: _____

CONSENT TO TREATMENT OF MINOR CHILD (if applicable)

As parent and/or legal guardian, I have the authority to authorize, and do hereby grant permission to the massage therapist at Crain Chiropractic & Wellness to administer massage services as she deems necessary to my son/daughter/ward.

Patient/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

Notes:

Therapist Signature: _____ Date: _____