



Cascade
**CHIROPRACTIC &
 NATURAL MEDICINE**

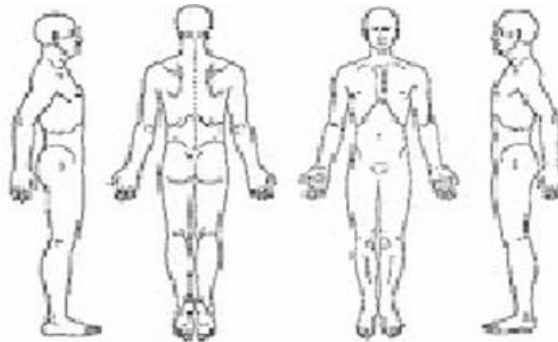
Massage Intake Form

Name _____ Date _____
 Phone (C/W) _____ Email _____
 Address _____
 City _____ State _____ Zip _____
 Date of Birth _____ Occupation _____
 Emergency Contact _____ Phone _____

What is the reason for your visit today? _____

When did symptoms start? _____

- Y N Is this due to an accident or injury?
- Y N Have you had a professional massage before?
- Y N Do you have any difficulty lying on your front, back, or side?
- Y N Are you currently under medical supervision?
 If yes, please explain _____
- Y N Are you currently taking any medication?
 If yes, please list _____
- Y N Are you pregnant? If so, how many months? _____



Circle any specific areas you would like the massage therapist to concentrate on during the session

Please check any condition listed below that applies to you:

- | | |
|--|--|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> phlebitis/deep vein thrombosis/blood clots/varicose veins |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> atherosclerosis/circulatory disorder |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> cancer |
| <input type="checkbox"/> current fever | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> decreased sensation | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> high or low blood pressure |

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.

Informed written consent must be provided by parent or legal guardian for any client under the age 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 massage 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 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. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____