



Massage Intake

Today's Date: ____/____/____ File: _____

Name: _____

Male Female SS#: _____

Date of Birth: ____/____/____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

Employer: _____

Occupation: _____

Phone: (H) _____ (Other) _____

In case of an emergency, contact: _____

Relationship: _____ Phone: _____

Marital Status: Single Married Divorced Separated
 Widowed Partnered Minor

Spouse's Name _____ Date of Birth: _____

Have you seen a chiropractor before? Yes No

If yes, what for: _____

How did you hear about our clinic? _____

Patient Condition

Reason for Visit: _____

When did your symptoms begin? _____

Is the condition getting worse? Yes No

Is the pain: Constant Comes and goes

Type of pain: Sharp Dull Throbbing Ache
 Tingle Numbness Shooting Burning
 Stiffness Cramping Swelling other _____

Rate the severity of pain (0-no pain, 10-severe): _____

Does it affect: Work Sleep Daily Activity

Activities that are painful: Sitting Lying down
 Standing Walking Bending All activity

Other Symptoms: Headache Pins/Needles in arm/legs
 Arm or leg pain Loss of smell or taste Numbness in fingers/toes
 Constipation/Diarrhea Cold hands/feet
 Shortness of breath Fatigue Upset stomach
 Depression Loss of balance Shoulder pain
 Ear ringing Loss of memory Chest pain Irritability
 Dizziness/fainting Nervousness Tension

Daily Habits

Sleep position: Stomach Side Back

Work Position: Sitting Standing Heavy labor Light labor
 Computer work Is your work station ergonomically correct? Yes No

Exercise: None Moderate Daily Heavy

Do you smoke? Yes No Packs/Day _____

Do you drink alcohol? Yes No Drinks/week _____

Do you drink caffeine? Yes No Cups/day _____

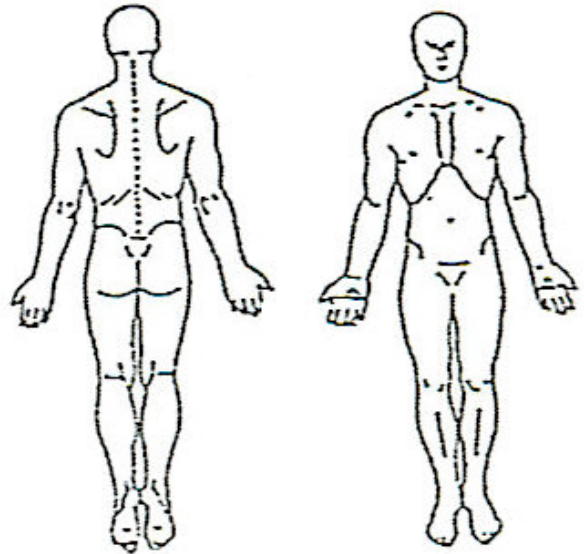
Do you have a high stress level? Yes No _____

What vitamins/supplements are you taking? _____

What medications are you taking? _____

Are you pregnant? Yes No Due Date: _____

Please mark an X on the picture of the involved areas:



Health History

Please mark the box next to each item if you *have had* any of the following:

- | | |
|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Pinched nerve |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Prostate problem |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Tumors, growths |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Herniated disk | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High blood pressure | _____ |
| <input type="checkbox"/> High cholesterol | _____ |
| <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Liver Disease | |

I certify that I have read and understand the above information and the questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature: _____

Date: ____/____/____