MUKILTEO CHIROPRACTIC CLINIC PLLC
8004 Mukilteo Speedway, Suite1 · Mukilteo, WA 98275

Massage Intake Form – CONFIDENTIAL INFORMATION

Name_____ Date of Birth_____ Male___ Female___
Social Security #_____ Marital Status: Single / Mar / Div / Other
Address_____City/St_____Zip_____
Home Phone_____Cell Phone_____Email_____
Occupation_____Employer_____Work Phone_____
How did you hear about our office?_____
Have you ever received massage therapy? _____ No _____ Yes
Is this visit as a result of an injury? _____ No _____ Yes (If Yes, circle Auto or Work injury.)

Insurance_____Subscriber Employer_____
Subscriber (if not self?)_____Subscriber Date of Birth_____
ID#_____Group#_____SSN_____

Please review this list and check those conditions that have affected your health either recently or in the past.
Place a check mark next to the condition.

___arthritis
___diabetes
___blood clots
___broken/dislocated bones
___bruise easily
___cancer
___chronic pain
___constipation/diarrhea
___auto-immune condition*
___hepatitis (A, B, C, other)
___skin conditions
___stroke
___surgery
___chemical dependency (alcohol, drugs)
(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)
___depression, panic disorder, psych condition
___TMJ disorder
___diverticulitis
___headaches
___heart conditions
___back problems
___high blood pressure
___insomnia
___muscle strain/sprain
___pregnancy
___scoliosis
___seizures
___whiplash
___numbness _____
___tingling_____
Other:_____

Are you currently taking any medications/Antibiotics? _____ No _____ Yes
If yes, please list names and reason for medications_____
_____

****A massage cannot be administered without your doctor's written consent if you are currently taking any Antibiotics.**

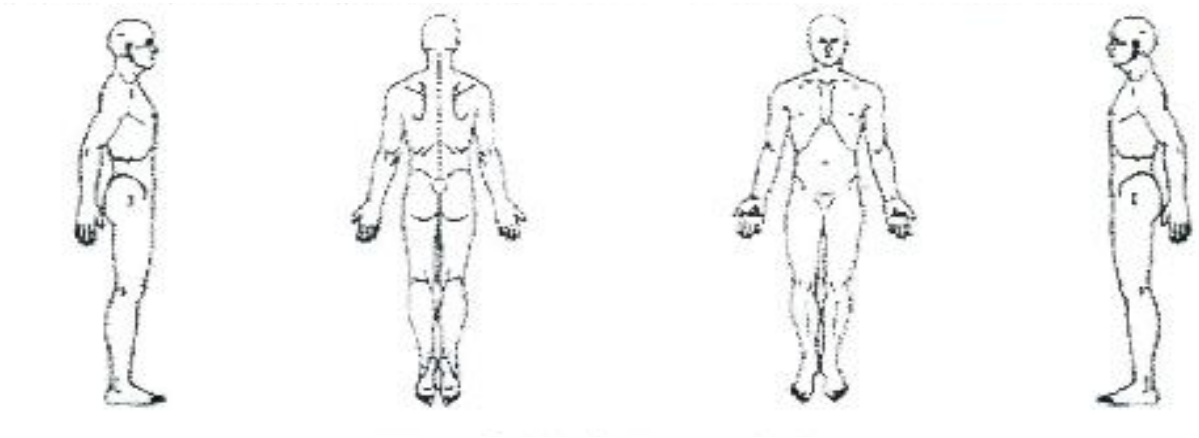
Do you have any of the following today: _____ skin rash _____ cold/flu _____ open cuts
_____ severe pain _____ anything contagious _____ injuries/bruises

**Please consult the Massage Therapist if you have or are recovering from a cold/flu, as receiving a massage may make you feel worse.

Do you have any allergies to: _____ Medications _____ Foods (nuts, etc.)
_____ Environmental allergens (dust, pollen, fragrances)
_____ Reactions to skin care products

If any of the above are checked, please give details: _____
_____

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session? _____
_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: move or change position, sighing, yawning, change in breathing, stomach gurgling, emotional feelings and/or expression, movement of intestinal gas, energy shifts, falling asleep, memories.

<u>Please read the following information and sign below:</u>

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should NOT be done under certain medical conditions, I affirm that I have answered all the questions pertaining to medical conditions truthfully.

Signature: _____ Date: _____