CAROLINA CHIROPRACTIC PLUS

Massage Intake Form

Patient Information:

Name:		Email:			
Street Address:					
City:		State:		Zip Code:	
Phone Number:		Occupation:			
DOB:		Referral:		Gender:	
Emergency Contact Name and Phone:					
Are you in pain? ◯ Y ◯ N		Areas of tension/pain:			
Is this your first professional massage? ◯ Y ◯ N		Last massage date:			
Primary reason for your visit:					

Please check all of the following which currently apply:

- ☐ Frequent Headaches
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Medical Device
- ☐ Seizures
- ☐ Arthritis
- ☐ Lymphedema/Lymph Nodes Removed
- ☐ Neuropathy
- ☐ High/Low Blood Pressure
- ☐ Osteoporosis (or Osteopenia)
- ☐ Herniated or Bulging Disc
- ☐ On Blood Thinners
- ☐ Bruise Easily
- ☐ Artificial Joints
- ☐ Hepatitis
- ☐ Varicose Veins
- ☐ Heart Disease
- ☐ Skin Allergies
- ☐ Cancer
- ☐ Kidney or Liver Disease

Are you currently taking any medications? ◯ Y ◯ N

Have you had surgery in the last 6 months? ◯ Y ◯ N

Are you pregnant? ◯ Y ◯ N How many weeks?

Based on the above information, we may need to modify your massage. In certain circumstances we may need to postpone your appointment.

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____