Moorhouse Chiropractic & Calm Massage Studio
Massage Intake Form

Name ____________________________________ DOB _____________________ Today's Date _______________

Address ____

City ____ State _____________________ Zip _______________________

Phone ____ Email ____

		YES	NO
1)	Have you had a professional massage before?	☐	☐
2)	Do you have any difficulty lying on your front, back, or side?	☐	☐
3)	Do you have any allergies to nuts, oils, lotions, or ointments?	☐	☐

4) Are there any areas of the body where you are experiencing tension, stiffness, pain or other discomfort?
If yes, please identify: ____
____

5) In the last 5 years, have you had any surgeries, fractures, sprains, strains, accidents, or injuries?
If yes, please explain: ____
____

6) Are you currently taking any medication?
If yes, please list: ____
____
____

Please check any condition listed below that APPLIES to you:

☐ contagious skin condition	☐ open sores or wounds	☐ stomach troubles/ulcers
☐ swollen glands	☐ easily bruising	☐ heart condition and/or pacemaker
☐ cancer	☐ radiation/chemotherapy	☐ artificial joint or implant of any kind
☐ current fever	☐ allergies/sensitivity	☐ AIDS/HIV Infection
☐ high or low blood pressure	☐ circulatory disorder	☐ varicose veins
☐ atherosclerosis	☐ phlebitis	☐ blood clots
☐ arthritis	☐ tendinitis	☐ anemia/sickle cell disease
☐ osteoporosis	☐ fainting/seizures/epilepsy	☐ headaches/migraines
☐ bleeding disorders/hemophilia	☐ diabetes	☐ decreased sensation
☐ hepatitis/jaundice	☐ fibromyalgia	☐ TMJ
☐ poor circulation	☐ thyroid imbalance	☐ respiratory problems/bronchitis
☐ asthma	☐ scoliosis	☐
☐	☐	☐ pregnancy? how many weeks? ________

☐ OTHER: ____

I understand that all bodywork services provided are given here for the purpose of stress reduction, relief from muscular tension or for increased circulation and energy flow. I understand that these services are not a substitute for medical or dermatological examinations and/or diagnosis and that it is recommended that I see a physician for any physical aliment that I might have. If I experience any pain or discomfort during this session, I will immediately inform the technician so that the pressure, strokes and/or procedure may be adjusted to my comfort level. I understand that the Massage Therapist's within this establishment are not qualified to diagnose, prescribe, or treat any illness, and that nothing said in the course of the session given should be construed as such. Because the Massage Therapist's must be aware of my existing physical conditions I have stated all my known medical conditions and I take it upon myself to keep Moorhouse Chiropractic and Calm Massage Studio updated on my physical health. I understand the service I am receiving today and I have no questions. I hereby release my Massage Therapist from any and all responsibilities and liabilities for the service I am requesting to receive.

____ ____
Signature Date Signature of Parent or Guardian Date

By signature above, I hereby authorize the technician at Moorhouse Chiropractic and Calm Massage Studio to perform the services I requested for my child or dependent.

LAST: ______________ FIRST: ______________