DC BODYWORKS
THERAPEUTIC MASSAGE

DONNELLY CHIROPRACTIC

CONFIDENTIAL HEALTH INTAKE FORM FOR MASSAGE THERAPY

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY:_____ ZIP: _____

PHONE: (____) _____ OCCUPATION: _____

WHAT IS YOUR PRIMARY REASON FOR YOUR APPOINTMENT?: _____

_____

PLEASE CIRCLE THE APPROPRIATE ANSWER TO THE FOLLOWING QUESTIONS AND PROVIDE CLARIFICATION, IF NECESSARY, ON THE LINE PROVIDED.

Do you have any medical conditions?	No	Yes	
Are you currently taking any medications? If yes, please list.	No	Yes	
Do you have any allergies or skin conditions?	No	Yes	
Are you currently under the care of a physician or health care provider?	No	Yes	
Do you exercise regularly or manage your stress in other ways?	No	Yes	
Have you had any recent surgery?	No	Yes	
Do you have or have you ever had cancer?	No	Yes	
Do you have any heart conditions?	No	Yes	
Do you have high or low blood pressure?	No	Yes	
Do you have varicose veins, blood clots, or any circulatory problems?	No	Yes	
Do you have diabetes? Type I or Type II?	No	Yes	
Do you experience migraine headaches or frequent tension headaches?	No	Yes	
Do you have any spinal problems?	No	Yes	
Do you have arthritis? If so, where is it located and what type?	No	Yes	

PLEASE COMPLETE REVERSE →

Do you have an infection or contagious disease?	No	Yes	
Are you currently experiencing a sleep disorder?	No	Yes	
Are you pregnant? If so, how far along?	No	Yes	
Do you wear contact lenses, a hearing aid, dentures or a wig?	No	Yes	

The following is a list of possible contraindications for massage. Please check to see if you have any of these conditions. If so, it may be necessary for us to have written permission from your physician before providing massage therapy in some of these circumstances.

	Acute Bronchitis/Emphysema (COPD)		Thrombosis (blood clot)
	Acute Lupus		Acute Rheumatoid Arthritis
	Cellulitis		Arteriosclerosis
	Cystitis/Nephritis (bladder/kidney infection)		Coronary Artery Disease
	Gout Arthritis		Glomerulonephritis
	Hepatitis		Hemolytic Anemia
	Septic Arthritis		Shingles
	Tuberculosis		

I understand that the massage therapy given through DC Bodyworks at Donnelly Chiropractic is for the purposes of stress reduction, relief from muscular tension or spasm, and/or increased circulation and energy flow. I understand that the massage therapy given here is not a substitute for medical examination or diagnosis and it is recommended that I see a physician for any physical ailment I might have. I have stated all my known medical conditions and take it upon myself to keep DC Bodyworks and Donnelly Chiropractic informed of any changes to my medical condition or physical health.

Client Signature _____ Date _____

Therapist Signature _____ Date _____