chiropractic lubbock

3624 50th Street Suite D
Lubbock, Texas 79413
PH: (806) 771-4444 FAX: (806) 771-4449

Patient #_________

Massage Therapy Intake Form

Today's Date ________/________/_______________
First Name __________________________________
M.I. ____ Last Name __________________________
Address _____________________________________
Unit# ________ City__________________________
State ______ Zip Code_______________-_________
Date of Birth ______/______/________ Age ______
Home # (_______)_________-__________________
Cell # (_______)_________-__________________

Work # (_______)_________-__________________
Email __________________@__________________
Marital Status □ Single □Married □ Other
Occupation__________________________________
Employer Name_______________________________
Emergency Contact ___________________________
Phone # (_______)__________-_________________
Relationship to Contact ______________________

How did you hear about our office? □ Existing Patient □ Family/Friend □Marketing Event □ Physician
Please specify: ____

Appointment Information

1) How will you be paying for your visit today? □ Cash □ Check □ Credit Card □ Gift Certificate

2) What type of massage are you requesting today?

SWEDISH……..... □30 minutes □60 minutes □90 minutes
COMBINATION. □30 minutes □60 minutes □90 minutes
DEEP TISSUE…..□30 minutes □60 minutes □90 minutes
"MOTHER-TO-BE:"……... □60 minutes
SPORTS……..……..… □30 minutes □60 minutes
REFLEXOLOGY....…..□30 minutes
TMJ……………….....…□30 minutes
FACE, SCALP, & NECK…□30 minutes

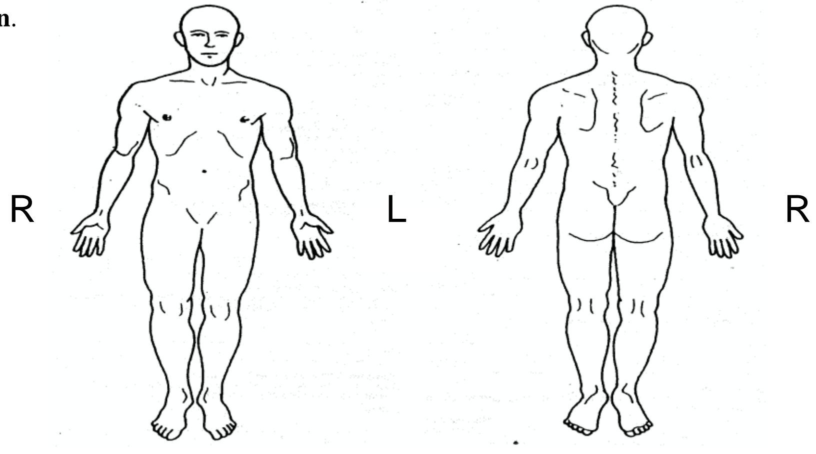
3) Have you ever had a professional massage before? □ Yes □ No
…..………..**3a) If yes, when was your last massage?** ____
……..……**3b) What type of massage? (ex. Swedish, Deep Tissue, etc)** ________________________________

4) What is your goal for today? ____

5) What type of pressure do you like? (Check all that apply) □ Light □ Medium □ Firm □ Deep

6) Are you *uncomfortable* with any of the following areas being massaged?
Gluteal Region □ No □Yes Feet □ No □Yes
Pectoral Region □ No □Yes Face/Scalp □ No □Yes

7) Please indicate the areas or regions of concern below. Mark specific regions using an "X". Circle general regions of concern.



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Client Health History

1) ***Please indicate any Present (P), Past (X), or Reoccurring (C) conditions:***

____ ADD/ADHD
____ Allergies
____ Alzheimer's disease
____ Anxiety disorder
____ Arthritis
 ____Osteoarthritis
 ____ Rheumatoid Arthritis
____ Athletes foot
____ Asthma
____ Blood Clot/ Deep Vein Thrombosis/ Phlebitis/ Embolism
____ Broken or fractured bones
____ Bursitis
____ Cancer
 --Location: ___________________
 --Treatment: __________________
 -- In Remission? Y/N
____ Carpal Tunnel Syndrome
____ Cerebral Palsy
____ Chronic Fatigue Syndrome
____ Contagious condition
____ Crohn's disease
____ Depression
____ Diabetes
 ____ Type I
 ____ Type II
____ Diverticulitis
____ Eczema
____ Epilepsy
____ Epstein Barr
____ Fertility Concerns
____ Fibromyalgia
____ General Fatigue
____ Gout
____ Headaches
 --Type: _____________________
 --Frequency: ________________
____ Hearing Impairment
____ Heart Condition

___Herpes/Shingles
___High/Low Blood Pressure
___High/Low Cholesterol
___HIV/AIDS
___Infection
___Lupus
___Lymphedema

____ Mononucleosis
____ Multiple Sclerosis
____ Muscular Dystrophy
____ Numbness/ Tingling
____ Osteoporosis/Osteopenia
 ____ Pain
 --Location: ____________________
 --Muscular or Joint: _____________
 -- Chronic? Y/N
____ Paralysis
____ Parkinson's disease
____ Pregnancy
____ Psoriasis
____ Rash
____ Sciatica
____ Scoliosis
____ Seizure
____ Sleeping problems
____ Spasms/ Cramping
____ Strain/ Sprain
____ Stroke
____ Tendonitis
____ Thyroid issues
____ TMJ/ Jaw Pain
____ Tumor
 --Location: ____________________
 --Malignant or Benign? ___________
____ Varicose Veins
____ Visually impaired
____ Other: _________________________
____
____
____
____

2) Please list any injuries/accidents/illnesses still affecting you:____
____
____

3) Please list any surgeries and explain :____
____

4) List any other health problems or concerns:____
____

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(Pregnancy Disclosure & Release Females only)

Are you pregnant? □ No □ Not Sure □ Yes

If you answer "Not Sure" or "Yes", please notify a staff member and the massage therapist before continuing.

By providing my signature below, I, ________________________________ (client), to the best of my knowledge, am NOT pregnant. I understand that by signing this release, I agree to hold K Chiropractic (company), and all of it's members, harmless of all complications that can result from receiving massage therapy while pregnant. I understand that I am required to notify K Chiropractic shall I ever become unsure or certain that I am pregnant.

____ ________________________________

Patient or Parent/Legal Guardian's Signature Date

Massage Therapy Consent & Release

1) I give my permission to receive massage therapy.
2) I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.
3) I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.
4) I have clearance from my physician to receive massage therapy.
5) I understand the risks associated with massage therapy include, but are not limited to:
• Superficial bruising
• Short-term muscle soreness
• Exacerbation of undiscovered injury
I therefore release the K Chiropractic and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.
6) I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.
7) I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.
8) I understand that I or the massage therapist may terminate the session at any time.
9) I have been given a chance to ask questions about the massage therapy session and my questions have been answered.
10) I understand and agree that if I cancel or reschedule my massage **24 hours or less** in advance of my appointment, I must pay a **$25 cancellation fee**.
11) I understand that if I **miss an appointment, do not show up to an appointment, or arrive more than 15 minutes late to my appointment**, I will be charged a **$40 no-show fee**.
I understand that certain conditions or medications may contraindicate (not permit) massage or may require the use of alternate techniques or pressure. I respect the decision of the massage therapist and am fully prepared to reschedule the massage for a later date if requested by the massage therapist. I also understand that massage may be advisable by my physician, but not by a massage therapist. In that event, I agree to provide a written agreement from my physician before proceeding with treatment.
By providing your signature below, you are attesting that all of the information you have provided to K Chiropractic and your therapist is true, and agree to have read, understand, and agree to the massage therapy release and consent.

____ ________________________________

Patient or Parent/Legal Guardian's Signature Date

______________________________	______________________________
Massage Therapist's Signature	Date