Massage Therapy Intake Form

First Name:_____ M.I.: _____ Last: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: _____ Marital Status: _____

Address:_____ City:_____ Zip:_____

Financial Responsibility: ( ) Self ( ) Parent or Guardian, name: _____

Occupation:_____ Employer:_____

Phone: Home ( ) _____ Work ( ) _____

Phone: Mobile ( ) _____ Email: _____

Referred By: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Number: _____

Reason for seeking a massage? _____

Have you had a professional massage before? _____ Is this the first visit to our office? _____

Briefly explain your current problem:_____

Is this problem as the result of a motor vehicle accident or work accident? ( ) Yes ( ) No

When did you first notice it?_____

Does your problem interfere with your: Job ( ) Sleep ( ) Daily Routine ( ) Other ( )_____

What activities aggravate the condition? _____

What helps the condition? _____

Is it getting: Better? ( ) Worse? ( ) Is it: Constant? ( ) Comes and goes? ( )

Are you currently being treated for this condition? _____

Have you been treated for this condition before? _____ If so, When? _____

Are you currently taking any medication? _____

Previous injuries or surgery? _____

Please check **ALL THAT APPLY:**

__Neck Pain/Stiffness	__Headache	__Dizziness	__High/Low Blood Pressure	__Diarrhea/Constipation
__Low Back Pain	__Muscle Tightness	__Nervousness	__Heart Problems	__ Arthritis
__Shoulder/Arm Pain	__Jaw Problems	__Insomnia	__Artery/Vein Problems	__Bacterial/Viral Infection
__Hip/Leg Pain	__Hearing Problems	__Fatigue	__Shortness of Breath	__Diabetes
__Numbness/Tingling	__Sinus Problems	__Allergies	__Cancer	__ Depression/Anxiety
__Wear Contacts?	__Thyroid Problems	__Stroke	__Trauma/Injury/Whiplash	

Some of the symptoms listed above may be originating from abnormal spinal structure and function.
Check ***Yes*** to have a consultation with one of our Doctors of Chiropractic.

__***Yes***, I would like to schedule a consultation following my massage.

__ ***No***, I waive the right to have a consultation, or I am already under chiropractic care.

2908 228th Ave SE Suite C * Sammamish WA 98075
Phone 425-391-4095 Fax 425-391-6059 www.PineLakeChiropractic.com

Massage Therapy Informed Consent

I understand that massage therapy provided by Pine Lake Chiropractic Clinic, P.S. and its LMT employees is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

The general benefits of massage, possible massage contraindications and treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not a part of massage therapy. I also understand that any illicit or sexually suggestive remarks or advance made by me will result in immediate terminations of the session, and I will be liable for payment of the scheduled appointment.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications and I will keep the massage therapist updated on any changes.

I have received and reviewed and understand and agree to the HIPPA Notice of Privacy Practices of Pine Lake Chiropractic Clinic, P.S.

I have received a copy of the Massage Therapist's and Financial Policies and I understand them and agree to abide by them.

Client Signature:_____ Date: _____

***Consent to Treatment of Minors*:**

By my signature below, I hereby authorized Pine Lake Chiropractic Clinic, P.S. to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____

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