Massage – Client Intake Form

Date_____

Name _____ Phone (primary) _____ (other)_____

Address _____ City _____ Postal Code _____

Email (*optional*) _____ Date of Birth (MM/DD/YY) 01 01 _____ Gender M / F

Occupation _____ Marital Status: S M W D Common-law Spouse Name_____

Emergency Contact _____ Phone _____

Physician _____ Phone _____

Massage Information

How did you hear about us? _____

Have you ever had a professional massage before? □ yes □ no

If yes, how often to you receive massage therapy? _____

Do you have any allergies? □ yes □ no

If so, please specify _____

Do you exercise regularly? □ yes □ no

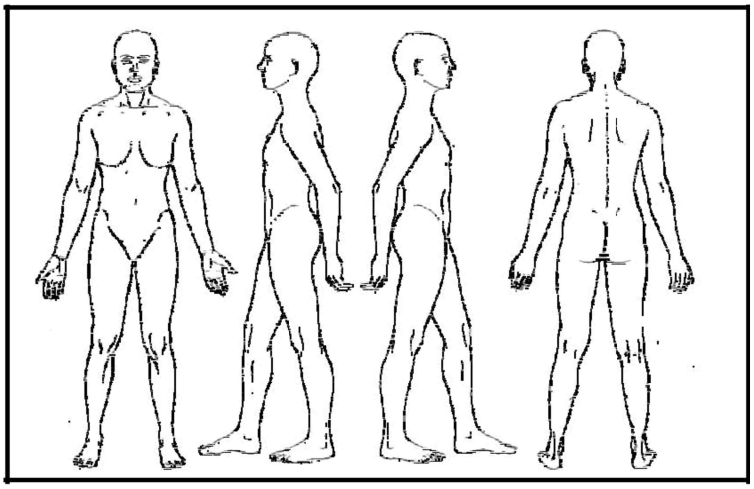
If so, what type(s)? _____

What are your common areas of pain or tension?

_____

_____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



SPINEGUYS Chiropractic, Massage, & Laser
232 McKnight Blvd N.E.
Calgary, AB T2K 6A5
(403)275-3800

Medical History

Do you suffer from chronic or persistent pain/discomfort?

_____

If so, for how long? _____

Do you know what caused it or when then symptoms seem to get worse or better? _____

_____

Do you see a chiropractor? □ yes □ no

If so, how often? _____

Are you currently under medical care? □ yes □ no

Are you currently taking any prescription medication? If so, for what? _____

_____

_____

Please indicate any conditions that you have had or currently have:

□ headaches, migraines	□ varicose veins
□ allergies, sensitivity	□ pregnancy
□ arthritis, tendonitis	□ blood clots
□ cancer, tumours	□ epilepsy
□ carpal tunnel syndrome	□ stroke/TIA
□ kidney disease	□ disc issues
□ scoliosis	□ osteoporosis
□ plantar fasciitis	□ multiple sclerosis
□ golfer's/tennis elbow	□ asthma
□ TMJ problems	□ diabetes
□ abnormal skin condition	□ paralysis
□ heart/circulation problems	□ fibromyalgia
□ joint replacement / surgery	□ numbness
□ high / low blood pressure	□ sprains, strains
□ motor vehicle accident	□ recent injuries

□ lack of or reduced feeling / sensation _____

Any other conditions not listed above:

_____

_____

I understand that massage therapy is an asset to my health, but does not take place of any medical care my physician may recommend. I have given the correct information regarding my health and am not aware of any reasons for not having massage therapy.

Client's Signature: _____ Date: _____