Massage Intake

First Name: _____ Last Name: _____ Date of Birth:_____

Address:_____ City:_____ State: _____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____ Consent to email appointment reminders & office updates : □ Yes □ No

Your Employer:_____ Occupation:_____

Marital Status:

□ Married Spouse's Name:_____
□ Single
□ Divorced
□ Widowed

Number of Children:_____ Ages:_____

How did you hear about us?

□ Friend who is a patient _____
□ Internet Search □ Event
□ Facebook □ Instagram
□ Drive By
□ Other:_____

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian of any client under the age of 17.

Draping will be used during this session –only the area being worked on will be uncovered.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/ or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Financial Policy: Payment is due at the time of services are rendered. We accept cash, check, and all major credit cards.

24 hour advance notice is required when canceling a massage appointment. This allows the opportunity for someone else to schedule an appointment. We have great clients and we understand life does not always allow for a full 24 hr notice. It is the full discretion of the Massage Therapist to waive/discount a cancellation fee but the official policy of Georgia Chiropractic and Massage is as follows;
Over 24 hrs notice - No fees imposed

Less than 24 hrs notice - $25 cancelation fee may be assessed. This fee will be required to be paid before booking the next appointment.

Skipped Appointments/No Shows - Same fee as the "Less than 24hrs notice" PLUS two 'NO Show'

appointments in 12 consecutive months will require a NON-REFUNDABLE pre-payment in order to schedule any future massage appointments.

Late Arrival - Should you arrive late to your appointment full payment for the scheduled massage is required and your session time will end on the previously scheduled time.

Signature of Client: _____ **Date:** _____

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Please flip over to complete medical history

Medical History: **In order to plan a massage session that is safe and effective, please answer the following questions about your medical history.**

Are you currently under medical supervision? : □ NO □ YES, for: _____

Do your currently see a chiropractor and/or physical therapist? □ NO □ YES, Provider(s): _____

Please identify if you are currently or have previously experience the following:

Musculoskeletal
□ N/A
□ Osteoporosis
□ Arthritis
□ Back Problems
□ Scoliosis
□ Hip Disorders
□ Neck Pain
□ Knee Injuries
□ Leg Pain
□ Poor Posture
□ Arm Pain
□ Shoulder Pain
□ TMJ
□ Fractures
□ Sprains
□ Strains

Integumentary
□ N/A
□ Skin Cancer
□ Psoriasis
□ Eczema
□ Acne
□ Hair Loss
□ Rash

Conditions
□ N/A
□ Cancer
□ Confusion
□ Spine or Disc generation
□ Pitting edema
□ Contagious Diseases
□ Memory Loss
□ Chronic Pain

Sensory
□ N/A
□ Blurred Vision
□ Ringing in the ears
□ Hearing Loss
□ Chronic Ear Infections
□ Loss of Smell
□ Loss of Taste

Digestive
□ N/A
□ Anorexia/Bulimia
□ Ulcer
□ Heartburn
□ Constipation or Diarrhea
□ Gas and Bloating
□ Ulcerative Colitis

Neurological
□ N/A
□ Parkinson's
□ MS
□ Anxiety
□ Depression
□ Headache
□ Dizziness
□ Pins/Needles
□ Numbness
□ Epilepsy
□ Seizures

Respiratory
□ N/A
□ Asthma
□ Apnea
□ Emphysema
□ Hay Fever
□ Shortness of Breath
□ Pneumonia

Constitutional
□ N/A
□ Fainting
□ Low Libido
□ Poor Appetite
□ Fatigue
□ Sudden Weight Change
□ Weakness

Genitourinary
□ N/A
□ Kidney Stones
□ Infertility
□ Kidney Dysfunction
□ Prostate Problems
□ PMS Symptoms
□ Pregnancy

Endocrine
□ N/A
□ Thyroid Issues
□ Immune Disorders
□ Hypoglycemia
□ Frequent Infection
□ Swollen Glands
□ Low Energy
□ Diabetes

Cardiovascular
□ N/A
□ High Blood Pressure
□ Low Blood Pressure
□ High Cholesterol
□ Poor Circulation
□ Angina
□ Excessive Burning
□ Blood Clots
□ Heart Disorders
□ Varicose Veins

List any conditions that would cause restrictions to perform massage techniques:

□ _____

□ _____

□ _____

□ _____

□ _____

□ _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Have you ever had a professional massage before? : □ NO □ YES _____

Do you have any difficulty lying on your front, back, or side? □ NO □ YES_____

Do you have any allergies or sensitivities to oils, lotions, or ointments? □ NO □ YES_____

Do you sit for long hours at a workstation, computer or spent long hours driving? □ NO □ YES_____

Do you perform any repetitive movement in your work, sports, or hobby? □ Yes □ No

If yes, please explain: _____

Is there a particular area of the body where you are experiencing tensions, stiffens, pain or other discomfort? □ Yes □ No

If yes, please identify: _____

Do you have any particular goals in mind for this massage session? □ NO □ YES_____