HealthWise
Family Chiropractic, P.A.

3803 Silver Lake Road NE, Unit 100

St. Anthony, MN 55421

Massage Intake Form

Patient Information:

Date: _____

Patient Name:_____ Date of Birth:_____ Age: _____ Gender:

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

Phone #:_____ May we text you with clinic updates/specials?

Email Address:_____ May we email you for appointment reminders?

How would you prefer to be contacted by our office? (scheduling, questions, concerns)

Email Phone Text Message Ok to leave detailed message?

Occupation:_____ Employed By:_____

Emergency Contact:_____ Phone:_____

How did you hear about us?

Personal Referral (name of patient): _____ (may we thank them for their referral?

Other (please specify):_____

Previous Providers:

Have you had massage before?

If yes, when was your last?_____

Have you currently seeing a chiropractor?

Are you currently seeing any other physician or healthcare professional?

If yes, who is the provider?_____

Reason for care:_____ Date of last visit:_____

Current Health and Habits:

What symptoms are you currently experiencing?_____

When did the symptoms begin?_____

Rate the severity of your pain (0=no pain, 10=unbearable pain!)_____

Describe your pain (check all that apply): Sharp Dull Throbbing Numbness

Shooting Aching Burning Tingling Stiffness

Has anything like this occurred before? (if yes, when?)_____

Did this condition begin suddenly or gradually?_____

Have you found anything that makes it better or worse?_____

Since it began, are the symptoms improving, worsening, or staying the same?_____

Have you been seen by another healthcare provider for this condition?_____

What treatment have you received?_____

Please list any rashes, skin conditions, or allergies:_____

Do you wear contact lenses or dentures:

Are you sensitive to any options, perfumes, or oils?:

Do you exercise regularly or participate in any sports?

Do you have any heart problems?

Do you have low blood pressure?

Do you have varicose veins or blood clots?

Do you have diabetes?

If so, when was the last time you ate?_____

Women Only:

Are you pregnant? (if yes, current gestational weeks) _____

Are you nursing?

Past Health History:

Please list any recent surgeries? _____

Consent to Treat:

I understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension and spasm, or for increasing energy flow. I understand that the massage therapist does not diagnose illness, disease, or physical or mental disorders. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand that massage therapy is not a substitute for medical treatment and/or diagnosis and that it is recommended that I see a physician for any physical ailments that I may have. I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical health.

Signature_____

No Call/No Show Policy:

Our massage therapists have a full schedule and when a patient is a no show or cancels at the last minute, they are preventing another patient from using that time slot. Consequently, we expect a phone call if you are unable to keep your appointment. If we do not hear from you by the time of your appointment, the credit card on file will be charged the full price of your missed appointment.

Signature:_____