HOLISTICHEALTH&NUTRITION
1164 S Roselle Rd. Schaumburg IL 60193 ● 847-301-0433 ● www.chiroholistic.com

Massage Intake Form

Name _____
Address _____
City/State _____ Zip Code _____
Home Phone _____ Cell Phone _____ Work _____
Occupation _____ Employer_____
Age _____ Date of Birth _____ Referred By _____
Have you ever had professional massage before? Yes _____ No _____
Primary reason for massage therapy _____
Areas of discomfort _____
How would you describe your general health? _____
Have you ever been hospitalized? Yes_____ No_____
If yes, please describe _____
Date of hospitalization _____
Are you currently under care of a physician? Yes _____ No _____
If yes, please describe _____
Physician's Name _____ Phone Number_____
When was your last examination? _____

Please check if you have any of the following:

___Allergies
___Arthritis, where_____
___Blood Clots
___Circulatory Problems
___Diabetes
___Heart Disease
___Hernia/Rupture
___High Blood Pressure
___Joint Disease
___Low Blood Pressure
___Muscular Injuries
___Skeletal Injuries
___Skin Problems
___Spinal Problems
___Varicose Veins

Please check any chronic problems you experience:

___Abdominal Pain
___Chest Pain
___Constipation
___Digestive Problems
___Dizziness
___Depression
___Fatigue
___Insomnia
___Migraine Headaches
___Sinusitis
___Other

Do you wear contact lenses? Yes ____ No ____
Do you wear dentures? Yes ____ No ____
Are you pregnant? Yes____ No_____

Do you exercise regularly or participate in any sports? Yes____ No____ If yes, what sport(s) and how often do you exercise? _____
Do you feel you eat a balanced diet? Yes____ No_____

Please describe your general consumption of the following:

	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Stress Level	_____	_____	_____	_____

Do you have or have had any other medical conditions, symptoms, or problems in regard to your health, fitness, or any body structure that I should be aware of prior to administering massage therapy?
If yes, please describe _____

I_____, understand the massage therapy at Holistic Health and Nutrition is for stress management, reductions of muscular tension, spasm and/or pain, and increasing circulation and energy flow. I understand that the massage therapist does not diagnose illnesses, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals nor do they perform any spinal manipulations. I know massage therapy is not a substitute for medical examination or diagnosis, and that Holistic Health and Nutrition recommends seeing a physician and chiropractor for physical ailments.

With this in mind, I agree that the massage therapists cannot be held liable for any problems that might arise as a result of my massage session.

I have stated all known medical conditions and take it upon myself to keep the massage therapist updated of my physical health.

Signature_____Date:_____