ANDERSON CHIROPRACTIC CENTER
131 W. HOLLY SPRINGS ROAD,
HOLLY SPRINGS, NC 27540
PHONE: 919-552-0751
FAX: 919-552-0891
WWW.ANDERSONCHIROPRACTICCENTER.COM
INFO@ANDERSONCHIROPRACTICCENTER.COM

ANDERSON
chiropractic center

Massage Health Intake Form

Name: _____ Best Contact Phone # ( )_____ Birth Date: ____/_____/_____

Address: _____City: _____ State: _____ Zip: _____

Email: _____Occupation: _____

{*Circle one*} Male / Female Marital Status_____ Number of Children_____

In case of emergency: _____Phone: ( )_____

Physician's Name: _____ Referred by: _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? {*Circle one*} Yes / No How recently?_____

What are your massage or bodywork goals?_____

What kind of pressure do you prefer? {*Circle one*} light medium firm

If you answer "yes" to any of the following questions, please explain as clearly as possible. {Please circle yes or no.}

Yes No Are you pregnant? How many weeks? _____
Yes No Do you have any contagious diseases? _____
Yes No Do you have any allergies? _____
Yes No Do you bruise easily?
Yes No Do you have diabetes?
Yes No Do you suffer from epilepsy or seizures? _____
Yes No Do you frequently suffer from stress?
Yes No Do you have cardiac or circulatory problems? _____
Yes No Do you have high blood pressure?
Yes No Are you taking high blood pressure medication?
Yes No Other medical condition, or are you taking any medications I should know about? _____
_____
Yes No Any broken bones in the past two years? _____
Yes No Do you have varicose veins?
Yes No Do you experience frequent headaches? _____

Yes No Do you have tension or soreness in a specific area? _____
Yes No Are you sensitive to touch or pressure in any area? _____
Yes No Do you have numbness or stabbing pains?_____
Yes No Do you suffer from arthritis? _____
Yes No Any injuries in the past two years? _____
Yes No Do you suffer from joint swelling?_____
Yes No Do you have osteoporosis? _____
Yes No Do you suffer from back pain? _____
Yes No Have you ever had surgery? _____
_____

Additional Comments:
_____
_____
_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork 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 of which I am aware. I understand that massage/bodywork practitioners 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/ bodywork should not 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Signature _____ Date : ____/_____/_____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent/Guardian_____Date: ____/_____/_____