TAHOE CHIROPRACTIC CLINIC
3121 Harrison Ave.
South Lake Tahoe, CA 96150
Phone (530)541-5660
Fax (866)899-6251

MASSAGE CLIENT INTAKE FORM

NAME: _____ I WOULD PREFER TO BE CALLED: _____

TODAY'S DATE: _____ /_____ / _____ WHO CAN WE THANK FOR REFERRING YOU?: _____

BIRTHDATE: _____ /_____ / _____ AGE: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ HOME PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____ OCCUPATION: _____

EMERGENCY CONTACT & RELATION:_____ PHONE NUMBER: _____

ARE YOU TAKING ANY MEDICATIONS? ☐ Yes ☐ No

If yes, please list name and use: _____

_____

ARE YOU CURRENTLY PREGNANT? ☐ Yes ☐ No

If yes, how far along? _____

Any high risk factors? _____

DO YOU SUFFER FROM CHRONIC PAIN? ☐ Yes ☐ No

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

ON A SCALE OF 1-10 (10 IS HIGH), RATE YOUR LEVELS OF:

Stress _____ Pain _____ Energy _____

HAVE YOU HAD ANY ORTHOPEDIC INJURIES? ☐ Yes ☐ No

If yes, please list: _____

Surgeries?: _____

DO ANY OF THE FOLLOWING THAT APPLY TO YOU?

☐ Cancer ☐ Stroke ☐ Headaches/Migraines ☐ Arthritis

☐ Diabetes ☐ Joint Replacement(s) ☐ Neuropathy

☐ High/Low Blood Pressure ☐ Fibromyalgia

☐ Heart Attack ☐ Kidney Dysfunction ☐ Blood Clots

☐ Numbness ☐Sprains or Strains

EXPLAIN ANY CONDITIONS YOU HAVE MARKED ABOVE:

_____

_____

_____

HAVE YOU HAD A PROFESSIONAL MASSAGE BEFORE?

☐ Yes ☐ No

WHAT TYPE OF MASSAGE ARE YOU SEEKING?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other _____

WHAT PRESSURE DO YOU PREFER?

☐ Light ☐ Medium ☐ Deep ☐ _____

DO YOU HAVE ANY ALLERGIES OR SENSITIVITIES (ESSENTIAL OILS, NUT OILS, SCENTS)? ☐ Yes ☐ No

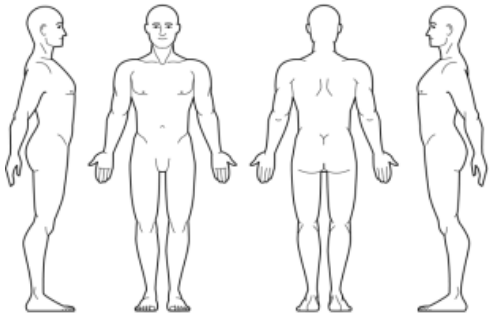
Please explain _____

ARE THERE ANY AREAS (FEET, FACE, ABDOMEN, ETC.) YOU DO NOT WANT MASSAGED? ☐ Yes ☐ No

Please explain _____

ARE YOU SENSITIVE TO TOUCH/PRESSURE IN ANY AREA (TICKLISH?)? _____

PLEASE CIRCLE ANY AREAS OF DISCOMFORT



By signing below, you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____

Date _____