

Cornerstone Chiropractic Inc. P.S.- Massage Intake Form

In order to maximize the effectiveness and safety of our sessions together, we ask that you take the time to fill out this confidential questionnaire carefully.

Name _____ Nickname _____ Date _____

Home Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ Age _____ Male Female • Single Married Divorced Widowed

Student: Full time Part time Non-student Social Security # _____

Employer _____ Occupation _____ Full time Part time

Employer's Address _____ City, State, Zip _____

Name of Spouse _____ Spouse's Birth Date _____

Spouse's Employer _____ Social Security# _____

Name and Age of Children _____

Person to contact in case of Emergency: _____ Phone _____

Is there any area where you would like extra time spent? Is there any area where you have muscle pain/stiffness/tension (neck, low back, shoulder, other)?

What is your previous experience with professional massage?

Daily Habits:

Do you exercise? Yes No Type of Exercise _____ Frequency _____

Do you smoke? Yes No How much per day? _____

Do you drink alcohol? Yes No Frequency and Amount _____

Do you drink coffee/tea/cafeinated beverages? Yes No Quantity _____

Height _____ Weight _____

Hobbies: _____

Medical History - Please indicate below any significant medical problems, as such conditions can influence the type and/or depth of work done in any given area. Thank you.

_____ Allergies

_____ Skin condition (acne, rash, allergies, skin cancer, other):

_____ Lymphatic condition (swollen glands, lymphoma, lymphedema, other):

_____ Recent injury or accident (whiplash, sprain, deep bruise, other):

_____ Circulatory condition (heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis, other):

_____ Neurological condition (sciatica, numbness/tingling of any area of skin, stroke, epilepsy, other):

_____ Joint problems, pain, or stiffness (osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, sacroiliac problems, other):

_____ Bone conditions (osteoporosis, previous fracture, cancer, other):

_____ Headaches (migraines, PMS, tension, cluster, other):

_____ Emotional difficulties (depression, anxiety, psychotic episodes, other):

_____ Stress

_____ Previous surgery, please state type and date:

_____ Other medical considerations:

_____ List any medications you are currently taking:

_____ Can you lie comfortably on your stomach? _____ Can you lie comfortably on your back? _____

_____ Are you pregnant?

_____ Do you have any body piercings that would be affected by heat (such as belly piercings)?

Name of Health Care provider: _____ Phone: _____

Signature _____ Date _____