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/caffeinated 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** ____________________