

# Client Intake Form – Therapeutic Massage

## Personal Information:

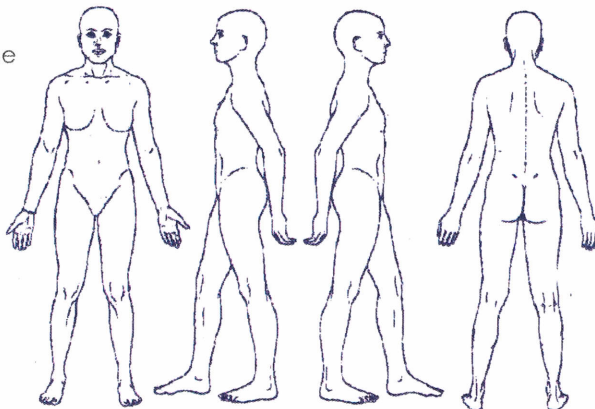
Name \_\_\_\_\_ Phone (Day) \_\_\_\_\_ Phone (Eve) \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
email \_\_\_\_\_ Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**The following information will be used to help plan safe and effective massage sessions.  
Please answer the questions to the best of your knowledge.**

Date of Initial Visit \_\_\_\_\_

1. Have you had a professional massage before? Yes No  
If yes, how often do you receive massage therapy? \_\_\_\_\_
2. Do you have any difficulty lying on your front, back, or side? Yes No  
If yes, please explain \_\_\_\_\_
3. Do you have any allergies to oils, lotions, or ointments? Yes No  
If yes, please explain \_\_\_\_\_
4. Do you have sensitive skin? Yes No
5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?
6. Do you sit for long hours at a workstation, computer, or driving? Yes No  
If yes, please describe \_\_\_\_\_
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No  
If yes, please describe \_\_\_\_\_
8. Do you experience stress in your work, family, or other aspect of your life? Yes No  
If yes, how do you think it has affected your health?  
muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other \_\_\_\_\_
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain  
or other discomfort? Yes No  
If yes, please identify \_\_\_\_\_
10. Do you have any particular goals in mind for this massage session? Yes No  
If yes, please explain \_\_\_\_\_

Circle any specific areas you would like the  
massage therapist to concentrate on  
during the session:



## Medical History

In order to plan a massage session that is safe and effective,  
I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No

If yes, please explain \_\_\_\_\_

12. Do you see a chiropractor? Yes No If yes, how often? \_\_\_\_\_

13. Are you currently taking any medication? Yes No

If yes, please list \_\_\_\_\_

14. Please check any condition listed below that applies to you:

- |   |  |
|---|--|
| <input type="checkbox"/> contagious skin condition  | <input type="checkbox"/> phlebitis   |
| <input type="checkbox"/> open sores or wounds       | <input type="checkbox"/> deep vein thrombosis/blood clots                              |
| <input type="checkbox"/> easy bruising              | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent accident or injury  | <input type="checkbox"/> osteoporosis  |
| <input type="checkbox"/> recent fracture            | <input type="checkbox"/> epilepsy  |
| <input type="checkbox"/> recent surgery             | <input type="checkbox"/> headaches/migraines   |
| <input type="checkbox"/> artificial joint           | <input type="checkbox"/> cancer  |
| <input type="checkbox"/> sprains/strains            | <input type="checkbox"/> diabetes  |
| <input type="checkbox"/> current fever              | <input type="checkbox"/> decreased sensation   |
| <input type="checkbox"/> swollen glands             | <input type="checkbox"/> back/neck problems  |
| <input type="checkbox"/> allergies/sensitivity      | <input type="checkbox"/> Fibromyalgia  |
| <input type="checkbox"/> heart condition            | <input type="checkbox"/> TMJ   |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> carpal tunnel syndrome  |
| <input type="checkbox"/> circulatory disorder       | <input type="checkbox"/> tennis elbow  |
| <input type="checkbox"/> varicose veins             | <input type="checkbox"/> pregnancy If yes, how many months?                            |
| <input type="checkbox"/> atherosclerosis            |  |

Please explain any condition that you have marked above \_\_\_\_\_

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? \_\_\_\_\_

Draping will be used during the session – only the area being worked on will be uncovered.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.

Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, \_\_\_\_\_ (print name) understand that the massage 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client \_\_\_\_\_ Date \_\_\_\_\_

Signature of Massage Therapist \_\_\_\_\_ Date \_\_\_\_\_



9320 Olde Eight Road  
Northfield Center, Oh 44067  
www.crossroads-chiro.com

# Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Email address: \_\_\_\_\_@\_\_\_\_\_

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: \_\_/\_\_/\_\_\_\_ Gender (Circle one): Male / Female Preferred Language: \_\_\_\_\_

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)  
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>For office use only</b> Height: _____ Weight: _____ Blood Pressure: _____ / _____
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**Crossroads Chiropractic & Acupuncture**  
9320 Olde Eight Road, Northfield Center, OH 44067  
(330) 467-0508 (p) ~ (330) 467-0140 (f)

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you. Please read the following, and if you have any questions, please feel free to ask one of our staff members.

### **Informed Consent:**

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Crossroads Chiropractic & Acupuncture, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

### ▪ **Women Only:**

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation. *(Circle one above)* *(Circle one above)*

▪ **Missed Appointments:** Please call the office as soon as possible if you will need to reschedule your appointment. Any **MASSAGE APPOINTMENT** that is not canceled **24 hours prior** to scheduled appointment will be charged **\$35**. Three (3) late cancellations for massage in 1 calendar year will result in a suspension of those services.

### ▪ **Outstanding Balances:**

There will be an **annual 18% interest fee** charged to any balance **30 or more days outstanding**.

### ▪ **Consent to Evaluate and Treat a Minor:**

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

### ▪ **Communications:**

In the event we would need to communicate your healthcare information, to whom may we do so?

Spouse/Partner: \_\_\_\_\_

Children: \_\_\_\_\_

Others: \_\_\_\_\_ No one: \_\_\_\_\_

May we leave messages regarding your personal healthcare information on any answering device? Yes [ ] No [ ]

May we contact you via email? Yes [ ] No [ ]

### ▪ **Acknowledgement**

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_