DOHNAL
CHIROPRACTIC
& WELLNESS

Massage Therapy Intake Form

Contact Information Date: _____

Name_____ Date of Birth _____ Male_____ Female_____

Street Address_____ City_____State _____ Zip_____

Cell_____ Work_____ Home_____

Email Address _____

Occupation_____

How did you hear about us? _____ Referred by _____

In Case of Emergency, please contact_____Phone_____

Relation to you_____

When is the best time to reach you? Morning _____ Afternoon_____ Evening_____

Which method of communication do you prefer? Phone _____ E-mail_____ Text_____

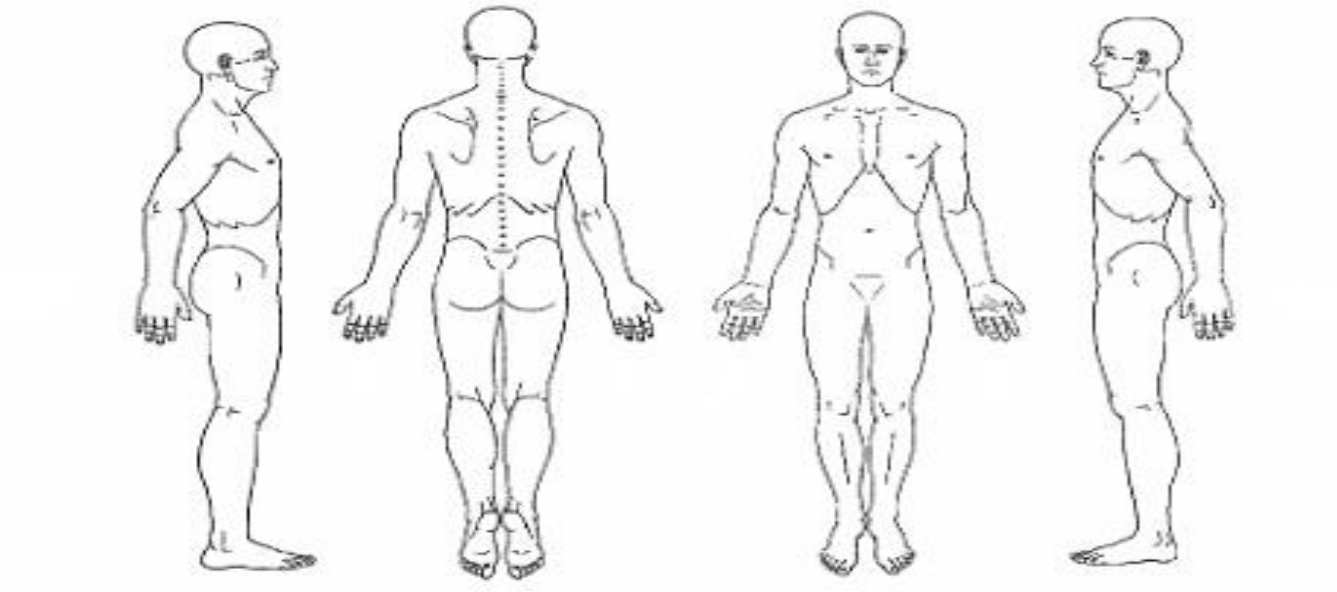
Can I call or text with any last minute cancellations: Yes_____ No_____

Have you had a professional massage before? Yes No

If yes, how often do your receive therapy? _____ When was your last massage? _____

Are you currently in pain or experiencing any discomfort? If so, please explain and indicate those areas on images below. (P= Pain, N= Numbness, S= Stiffness)

Describe any pain/tension you are currently experiencing _____



What makes it feel better? _____

What makes it feel worse? _____

Are you currently under the care of a physician, chiropractor or alternative medical practitioner? No Yes

If yes, what are you being treated for? _____

_____

Are you currently receiving any other body or energy therapies? _____

If yes, please explain? _____

Please list any medications (prescription or non-prescription), vitamins and supplements you are currently taking

_____

_____

_____

Please check any of the following that apply to you currently or in the past.

Condition/Concern	Past	Present	Condition/Concern	Past	Present
Allergies			Herniated or Bulging Discs		
Anxiety			High or Low Blood Pressure		
Arthritis			Joint Disorder/Rheumatoid Arthritis/Osteoarthritis/Tendonitis		
Artificial Joints			Loss of Memory		
Atherosclerosis			Loss of Smell/Taste		
Auto-Immune Disorder			Migraines		
Back Problems			Muscular Tension		
Blood Clots/DVT			Neck Problems		
Bruise Easily			Neurological Problems		
Cancer			Open Sores or Wounds		
Carpal Tunnel Syndrome			Pacemaker		
Circulatory Disorder			Painful/Swollen Joints		
Cold Hands/ Cold Feet			Panic Attacks		
Constipation/Diarrhea			Phlebitis		
Contagious Skin Condition			Pins & Needles in Arms, Legs, Hands or Feet		
Currently have a Fever			Plantar Fasciitis		
Decreased Sensation			Sciatica		
Deep Vein Thrombosis/Blood Clots			Sinus Condition		
Depression			Sleep Disturbance		
Diabetes			Spinal Problems		
Epilepsy or Seizures			Sprains or Strains		
Fainting Spells			Surgeries		
Fibromyalgia			Swollen Glands		
Frequent Colds			Tennis Elbow		
Headaches			TMJ		
Heart Condition			Varicose Veins		

Please list all injuries, accidents and surgeries. Please provide the approximant date as well.

_____

_____

_____

The following information will be used to help plan a safe and effective massage session, please answer the questions to the best of your knowledge.

Do you have sensitive skin? Yes No

If so, please explain _____

Do you have any known allergies? Yes No

If yes please explain_____

Do you have any known sensitivities to essential oils, lotions or scents? Yes No

If yes please be specific _____

Are you currently pregnant? _____ How far along are you? _____

Is this considered a high risk pregnancy? _____If yes, please explain _____

_____

Are you currently wearing contact lenses? Yes No Hearing aid(s) Yes No

Do you sit for long hours at a workstation, computer or driving? Yes No

If yes please describe_____

Do you perform any repetitive movement in your work, sports or hobby? Yes No

If yes please describe_____

Do you experience stress in your work, family or other aspects of your life? Yes No

If yes, how do you think it has affected your overall health? (*Check all that apply below*)

( ) Muscle ( ) Tension ( ) Anxiety ( ) Insomnia ( ) Irritability ( ) Other

How frequently and for how long do you exercise and what do you do? Include sports, Pilates, Yoga, gardening and/or physical activity._____

Do you have difficulty lying on your stomach or back? Yes No

If yes, please explain _____

Are there any areas you do **NOT** like massaged (i.e. feet, stomach, head, face):_____

What do you hope to accomplish with this massage _____

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? _____

The following sometimes occurs during massage; they are normal responses to relaxation. Trust your body to express what it needs: *Need to move or change position *Sighing, yawning, change in breathing * Stomach gurgling * Emotional feelings and/or expressions * Movement of intestinal gas * Energy Shifts * Falling asleep * Memories

- I understand the treatment here is not a replacement for medical care**. Initial**: _____
- As such, the massage therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she preform any spinal manipulations (unless specified under his/her professional scope of practice) **Initial:** _____
- I understand that the treatment is not a substitute of medical treatments and/or a diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have**. Initial**: _____
- I have stated all my known conditions and take it upon myself to keep the massage therapist/practitioner updated on my health**. Initial**: _____
- I am 14 yrs. of age or younger and I must have a legal guardian in the massage room for the entire massage session. If I am between 15 yrs-17 yrs. of age and my legal guardian is present at Dohnal Chiropractic & Wellness, if my legal guardian chooses not to be in the massage room. **Initial**_____
- I understand that payment is due at the time of treatment unless other arrangements have been made. **Initial:** _____

*****PROPER HYGEINE IS REQUIRED OF BOTH CLIENT AND THERAPIST*****

Late Start

I understand that to get the most from my session, and to be fair to the massage therapist and other clients, sessions start and end on time. I understand that if I am late, this may results in a shortened session, in which I will still pay the full amount. **Initial**: _____

Massage Cancellation Policy

Cancelling Your Appointment:

Dohnal Chiropractic & Wellness understands unforeseen circumstances occur. As a courtesy, we will allow a one-time grace period of the cancellation policy without penalty. Further appointments may require a payment in full to hold the reservation. **Initial** _____

-I understand that if I fail to arrive for an appointment without 24-hr. cancellation notice that session is considered missed, and I will pay the full amount for the missed appointment. I understand that any gift certificate and/or prepaid packages associated with my appointment will count as services rendered**.**

Initial _____

-Your appointment may be rescheduled 24 hours prior to your appointment without penalty.

Initial _____

To reschedule your appointment, please call the office **directly at (615) 781-8181**

I have read and understand the above policies. (Please sign & date below)

_____ _____ (Date)