

Elmenhurst Chiropractic Clinic

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Massage Therapy Initial Intake Form

File# _____

Name: _____

Date: _____

First MI Last

Mailing Address: _____ City _____ State _____ Zip _____

Ph#:(hm) _____ (wk) _____ (cell) _____ SS# _____ DOB: _____ Sex M F

Marital Status: M S W D Number of Children: _____ Occupation: _____ Employer: _____

Name of Spouse/Partner _____ Emergency Contact: _____ Ph# _____

Who may we thank for referring you to us? _____ Referring doctor: _____

Ph#: _____ May we contact them if pertinent: Y/N Currently Pregnant Y N Possible

Will we be billing insurance for you? Yes No ID# _____ Group# _____ Ins. Co. _____

Subscriber _____ Subscriber's DOB _____ Subscriber's SS# (for billing purposes) _____

In which part(s) of your body do you feel stress most often?

- | | | |
|-------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> head | <input type="checkbox"/> neck | <input type="checkbox"/> shoulders |
| <input type="checkbox"/> back | <input type="checkbox"/> extremities | <input type="checkbox"/> other: |

Recent injuries *not* requiring surgery (including broken bones): _____

Recent surgeries with approximate dates (within the last year): _____

Please review this list and circle any illnesses and/or conditions that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> contact lenses | <input type="checkbox"/> ruptured/bulging discs |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> heart condition | <input type="checkbox"/> pins/needles/numbness/tingling |
| <input type="checkbox"/> seizures | <input type="checkbox"/> skin disorder | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> cancer | <input type="checkbox"/> varicose veins/phlebitis | <input type="checkbox"/> infectious conditions |
| <input type="checkbox"/> stroke | <input type="checkbox"/> painful joints | <input type="checkbox"/> auto-immune disorder |
| <input type="checkbox"/> scoliosis | <input type="checkbox"/> previous MVA/trauma | <input type="checkbox"/> headache |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> fatigue/depression | <input type="checkbox"/> bruxing/grinding teeth |
| <input type="checkbox"/> other: | | |

Medications:

- | | | |
|---|---|---|
| <input type="checkbox"/> muscle relaxants | <input type="checkbox"/> prescription pain reducers | <input type="checkbox"/> anti-inflammatory |
| <input type="checkbox"/> over-the-counter pain reducers | <input type="checkbox"/> sleeping pills | <input type="checkbox"/> anti-anxiety/depressants |
| <input type="checkbox"/> other: | | |

Please list any vitamins, minerals, and/or herbs that you regularly take: _____

What are your goals for massage therapy? _____

Are there any areas that you would prefer *not* to be massaged?

- | | | |
|----------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> face | <input type="checkbox"/> scalp | <input type="checkbox"/> hands |
| <input type="checkbox"/> legs | <input type="checkbox"/> feet | <input type="checkbox"/> back |
| <input type="checkbox"/> arms | <input type="checkbox"/> neck | <input type="checkbox"/> chest |
| <input type="checkbox"/> abdomen | <input type="checkbox"/> buttocks | |

I agree to provide complete and accurate health information, and give notice of health changes at successive appointments as appropriate.

- Massage Therapy Policy

Signature: _____ Date: _____