

GUTHRIE CHIROPRACTIC & MASSAGE

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MASSAGE TREATMENT / Confidential Patient Intake Form

Patient Name _____ Phone # _____

Address _____

Reasons for your visit? _____

Please state any recent injuries or illness: _____

Specify any past surgeries or hospitalizations: _____

Have you any of the following? (please circle)

abnormal blood pressure	allergies to massage oil	arthritis	bruises
diabetes	fever	heart/kidney/lung disease	joint dislocations
localized infection	neck/spinal injury	numbness	osteoporosis
pregnancy	seizures	skin disorders	stroke
ulcerated colon	varicose veins or clotting problems		

Please explain any "circled" answers _____

Are you currently under the care of a health care professional? Yes No

Provider's Name _____ Phone # _____

Medications _____

Have you had massage therapy before? Yes No

What are your massage likes and/or dislikes? _____

Where are your primary areas of pain, soreness or tension? _____

Signature _____ Date _____