REGIONAL CHIROPRACTIC CENTER
LAKE NORMAN
736 Brawley School Road • Suite E • Mooresville, NC 28117
Office: 704-664-1031 • Fax: 704-664-1035 • www.regionalcc.com

Massage Intake Form

Personal Information:

Name: _____ Date: _____

Address:

_____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Home: _____ Work: _____ Cell: _____

Occupation: _____ Email Address: _____

Who referred you for treatment?

_____

Do you have a Chiropractor? _____ Last time seen: _____

Additional Information:

What is the PRIMARY complaint that brings you in for treatment today? _____

_____

Any secondary complaints you would like to address today? _____

Would you like me to focus on **OR** stay away from any specific area? _____

_____

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Please check any of the conditions you've had in the past or currently have:

____ Cardiovascular Disease	____ Neurological Condition	____Sinus Problems
____ Arthritis (Osteo/Rheum)	____ Depression	____ Anxiety
____ Asthma/Difficulty Breathing	____ High Blood Pressure	____ Pregnancy
____ Vertigo/Dizziness	____ Constipation/Diarrhea	____Digestive Issues
____ Varicose Veins	____Thyroid Condition	____ Fibromyalgia
____ Diabetes (Type 1 or 2)	____ Multiple Sclerosis	____ Tendonitis
____ Numbness/Tingling	____ Osteoporosis	____ Sprains/Strains
____ Chronic Infections	____ Epilepsy/Seizures	____ HIV/AIDS
____ Kidney Disease	____ Chronic Fatigue Syndrome	____ Blood Clots
____ Congestive Heart Failure	____ Headaches/Migraines	____ Tension/Stress
____ Muscle/Joint Pain	____Rash/Skin Conditions	____ Back/Neck Pain
____ Eyestrain/Irritation	____ Chest Pain/Tightness	____ Sleep Disorders
____Menstrual Issues	____ Earaches/Ringing in Ears	____ TMJ/Jaw Pain

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE AND TRUE. IF MY MEDICAL/HEALTH STATUS SHOULD CHANGE, I WILL INFORM MY THERAPIST IMMEDIATELY.

I understand myofascial release/bodywork may be contraindicated. I also understand that bodywork 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 is beyond the scope of practice of my massage therapist. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness. Because myofascial release/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and have answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand there should be no liability on the part of the therapist should I forget to do so. It is also my understanding that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment of the scheduled appointment. I understand I will be charged for appointments I cancel or miss without 24 hours notice of my scheduled appointment. I also understand that if I arrive late I will receive the remainder if the time scheduled, but will be liable for payment in full.

Client Signature: _____ **Date:** _____

Parent or Guardian Signature (if minor) _____