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SPECIALIZING IN MANUAL THERAPY NCTMB #543450-07 LIC #227.008913
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Manual Therapy Intake Form

Confidential Information

Welcome! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know!

Date: _____

Patient Name: _____ Date of Birth: _____

Address:_____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email Address: _____Occupation: _____

How did you learn about this clinic? _____

Have you ever received massage or manual therapy? _____YES _____NO

Type of massage (Swedish, Shiatsu, deep tissue, etc.):_____

Have you been treated by a doctor for any health conditions in the last year?

If yes, please describe:

_____

_____

Are you currently taking any medications? (please list all):

_____

Please review this list and check those conditions that have affected your health either recently or in the past.

___ Arthritis

___ Diabetes

___ Blood clot

___ Broke/dislocated bones

___ Bruise easily

___ Cancer

___ Constipation/diarrhea

___Auto-immune condition

(AIDS, fibromyalgia, chronic fatigue, lupus etc)

___Diverticulitis

___ Headaches

___ Heart conditions

___ Back problems-specify:_____

___ High blood pressure

___ Insomnia

___ Muscle strain/sprain

___ Pregnancy

___ Hepatitis (any variation)

___ Skin conditions

___ Stroke

___ Surgery

___ Scoliosis

___ Seizures

___ Whiplash

___ Chemical dependency (alcohol, drugs, cigarettes)

___ TMJ

___ Caffeine use

___ Depression, panic disorder/other psych conditions

- Do you have any of the following today?

___Skin rash ___Cold/flu ___Open cuts ___Severe pain ___ Anything contagious ___Injuries/bruises

- Do you have any allergies to:

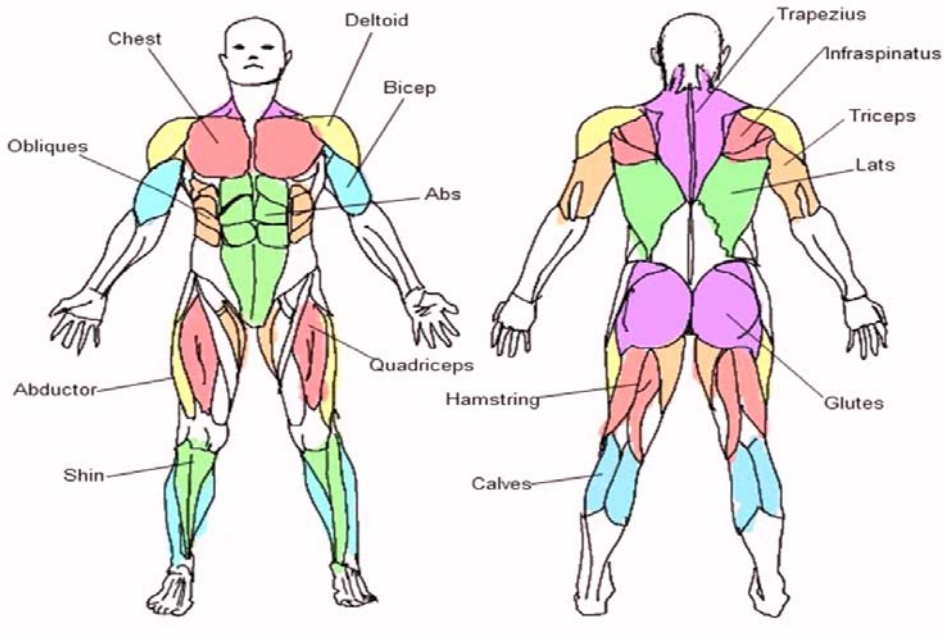
___Medications ___Foods (nuts, etc.) ___Environmental allergens (dust, pollen, fragrances, etc)

___Reactions to skin care products

If yes to any, please describe:_____

- Are you wearing: ___Contact lenses ___Hearing aid ___Hairpeice

Please indicate with an (X) any areas which you are feeling discomfort:



What are your goals/expectations for this therapy session?

_____

_____

_____

_____

Please be aware that the following sometimes occur during manual therapy. They are normal responses to relaxation. Trust your body to express when it needs to: -move or change positions –sigh, yawn, or change breathing –make stomach noises/gurgling-emotional feelings and/or expression –movement of intestinal gas –energy shifts –fall asleep –relay memories

Please read the following information and sign below:

- I understand that although massage/manual therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for regular medical examination, diagnosis or treatment.
- This is a therapeutic massage/therapy, any inappropriate remarks or advances during treatment will terminate the session and the patient will be liable for full payment of the scheduled appointment.
- Being that massage/therapy should not be done under certain medical conditions, I affirm that all medical questions/conditions are answered truthfully.

Signature_____

Date_____