COBERLY CHIROPRACTIC

3025 N. Taft Avenue, Suite A
Loveland, Colorado 80538
Phone: 970.203.0621
Fax: 970.461.2462

Massage Intake Form

Please complete this information to help the therapist get to know you and so your therapy can be customized to your needs. All of this information is important because it describes your lifestyle. This information is confidential is will only be used in the development of your massage therapy treatment plan.

Basic Data

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____

Cell Phone _____ Other Phone _____ Age _____ Birth Date _____

Marital Status _____ Spouse's Name _____ Number of Children _____

Height _____ Weight_____ Whom can we thank for referring you? _____

Occupation _____ Employer _____

Work Status: ☐ Fulltime ☐ Part-time ☐ Homemaker ☐ Unemployed ☐ Student

Indicate if we are seeing you for an injury from: ☐ Auto ☐ Sports ☐ Work ☐ Other ☐ No Injury

Emergency Contact _____ Home Phone _____Cell Phone _____

Health History

Physical activities at work:

_____ % Sitting _____ % Standing _____% _____

_____ % Walking _____ % Computer _____%_____

_____ % Lifting _____ % Repetitive Motion _____%_____

List the amount of time spent on each daily activity when not at work.

_____ Sitting _____ Standing _____ Walking _____ Other

_____ Computer _____ Lifting _____ Exercise _____ Other

_____Video Games _____House Work _____Other _____ Other

Hobbies, leisure time, sports, & time spent: (Golf, Reading, Gardening, TV, Crafts, Etc.)

_____

_____

_____

Have you ever had a professional massage before? ☐ No ☐ Yes Frequency _____

When was your last massage? _____ What pressure do you prefer? _____ Light _____ Med _____ Deep

What results are you looking for from your massage? _____

_____

Do you have any concerns about getting a massage?_____

_____

General Health—Please check any illnesses or conditions you have now or had in the past

	Current	Past
Bone or Joint Disease	☐	☐
Bursitis/Tendonitis	☐	☐
Spasms/Cramps	☐	☐
Broken/Fractured Bones	☐	☐
Arthritis _____	☐	☐
Heart Condition	☐	☐
Vascular Problems	☐	☐
Blood Clot	☐	☐
Aneurysm	☐	☐
Blood Pressure Low/High	☐	☐
Edema	☐	☐
Breathing Problems	☐	☐
Sinus Problems	☐	☐
Allergies	☐	☐
Rash	☐	☐
Athlete's Foot/Warts	☐	☐
Sprains/Strains	☐	☐
Back Pain	☐	☐
Hip Pain	☐	☐
Leg/Foot Pain	☐	☐
Neck Pain	☐	☐
Constipation	☐	☐
Irritable Bowel	☐	☐
Diverticulitis	☐	☐
Herpes/Shingles	☐	☐

	Current	Past
Chronic Pain	☐	☐
Neuroma	☐	☐
Fatigue	☐	☐
Insomnia	☐	☐
Sleep Disorder	☐	☐
Pregnant _____ months	☐	☐
Menopause	☐	☐
Shoulder Pain	☐	☐
Arm/Hand Pain	☐	☐
Headache/Head Injury	☐	☐
Lupus/Fibromyalgia	☐	☐
Chronic Fatigue/Syndrome	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Thyroid Problems	☐	☐
Liver Disease	☐	☐
Eating Disorders	☐	☐
Depression	☐	☐
Bipolar Disorder	☐	☐
Drug/Alcohol Addition	☐	☐
Infectious Disease:	☐	☐
Other: _____	☐	☐
Other: _____	☐	☐
Other: _____	☐	☐

List all medications and what they are for (including non-prescription): _____

_____

Please list any **old** Injuries over a year ago and the dates of occurrence: _____

_____

Please list any **new** Injuries less than 1 year and the dates of occurrence: _____

_____

Surgeries and Date: _____

_____

How much water do you drink daily? _____ Do you smoke? ☐ No ☐ Yes _____ Number per Day

Number of alcoholic drinks per day _____ Do you use illicit drugs? (Yes, I need to know.) ☐ No ☐ Yes

Nutrition and Diet: Check any that apply to you.

☐ Healthy w/meat or
☐ Vegetarian

☐ I try to eat healthy, but could do better

☐ I love junk food, snacks, fast food

☐ I take time to eat or
☐ I eat in a hurry

☐ I eat at my desk or in front of the TV

☐ I use sugar or
☐ I use sugar free products

☐ Number of servings of fruit/veggies per day

☐ I cook most of my food or
☐ I eat out a lot

☐ I eat alone or
☐ I eat with my family

☐ I worry about my weight

Consent

1. It is my choice to receive massage therapy.
2. I understand that massage therapy is beneficial for relaxation, relief from pain, tension, and stress.
3. I agree to communicate fully with my therapist in regard to my health and massage experience.
4. I understand that massage therapists do not diagnose illness, disease, or mental disorders, nor do they prescribe any medical treatment, pharmaceuticals, or perform any spinal manipulations.
5. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is advised that I see a primary care provider for that service.
6. I have truthfully stated all medical and health conditions that I am aware of, and will inform the therapist of any changes in my health status.
7. I am aware that not informing the therapist of critical health information could result in injury due to contraindications for massage.

_____ _____

Patient Signature or Legal Guardian Date