BLAINE CHIROPRACTIC & MASSAGE

Massage Therapy Intake Form

Name: _____

Address: _____

City:_____ **State:**_____ **ZIP:**_____

Phone (Home):_____ **Cell:**_____

Date of Birth:_____/_____/_____
Email:_____

Emergency Contact Name & Phone:

_____

1) Primary Care Provider (PCP)

Name:_____

Clinic:_____

Phone:_____

2) Current Health Information

Main reason for visit:

_____

When did the issue begin?

_____

☐ Better ☐ Worse ☐ No Change

☐ Seen other providers: Yes ☐ No

If yes, who:

_____

3) Activities Limited by Condition

☐ Work ☐ Exercise ☐ Sleep ☐ Household chores

☐ Driving ☐ Sitting ☐ Standing ☐ Walking **Other:**

_____

4) Self-Care and Stress Reduction

☐ Stretching ☐ Exercise ☐ Ice/Heat

☐ Over-the-counter meds ☐ Rest

☐ Other:_____

5) Previous Massage Therapy

Had massage before: ☐ Yes ☐ No

Helpful: ☐ Yes ☐ No

Goals for massage therapy:

_____

6) Health History (Past & Present Conditions)

☐ Allergies ☐ Arthritis
☐ Autoimmune disorders ☐ Blood clots
☐ Cancer ☐ Diabetes
☐ Fibromyalgia ☐ Headaches/Migraines
☐ Heart conditions ☐ High blood pressure
☐ Low blood pressure ☐ Joint replacement
☐ Medical Device Implantation
☐ Neurological conditions ☐ Pregnancy – Due Date:
☐ Skin conditions ☐ Spine problems
☐ Recent surgery/injury (last 6 months)

Other/Explanation of Checked:

_____

_____

7) Activity Level

☐ Active Daily ☐ Moderate Activity ☐ Sedentary

8) Water Intake

☐ Super Hydrator ☐ When Thirsty ☐ Dry Desert

Contract for Care

I understand that massage therapy is a therapeutic health aid and is not a substitute for medical diagnosis or treatment. I agree to communicate with my therapist openly about any discomfort or health concerns during the session. I understand that no inappropriate behavior will be tolerated and may result in immediate termination of the session.

Initial Contract for Care _____

Consent for Care

I voluntarily consent to receive massage therapy from Blaine Chiropractic and Massage. I understand that massage therapy involves physical touch and will be performed in a professional manner. I agree to inform the therapist of any changes in my health status.

Initial Consent for Care _____

Insurance Billing and Payment Agreement

I authorize Blaine Chiropractic and Massage to bill my insurance on my behalf. I understand that I am financially responsible for any portion not covered by insurance, including copayments, deductibles, or denied services. I agree to pay all balances due in full.

Initial Payment Agreement _____

I confirm that all information provided is current and correct to my knowledge

Patient Signature: _____

Date: _____

Parent/Guardian Signature (if under 18):

_____

Relationship:

_____