Mountain View Chiropractic

5001 N Granite Reef Rd. Ste B – Scottsdale, AZ 85250
(480) 941 – 2454

MASSAGE CLIENT INTAKE FORM

Patient Name:	**Date:**
Phone Number:	**Address:**
Email Address:	**City, Zip:**
Date of Birth:	**Referred By:**
In case of emergency, please contact: **Phone #:** **Relationship:**	
Primary Reason for Visit:	
May we email you important information about office hours and seasonal specials? Yes No	

Massage History

Have you ever received a professional massage? ☐ **Yes** ☐ **No**
Please indicate frequency:
Desired Pressure: ☐ **Light** ☐ **Medium** ☐ **Firm** ☐ **Deep**
Please check below areas of your body that you give permission to receive massage: ☐ **ALL OF THE BELOW**
☐ **Back** ☐ **Legs** ☐ **Buttock** ☐ **Arms** ☐ **Pecs/Chest** ☐ **Abdomen** ☐ **Neck** ☐ **Head** ☐ **Face**

Is there any additional information you feel the Massage Therapist should know? Would you like additional information on any of our services? ____

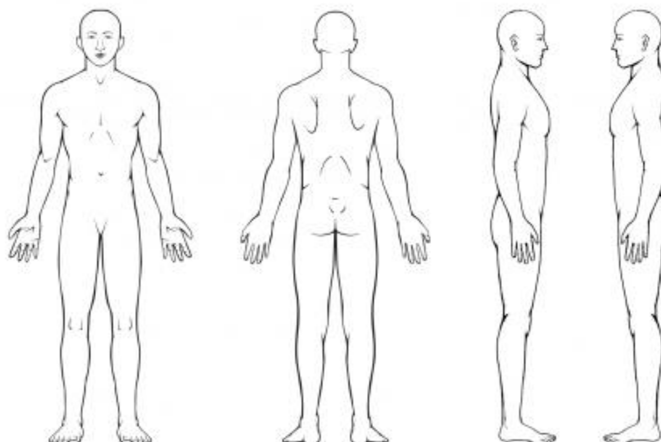
____

HEALTH HISTORY

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

☐	Neck Pain	☐	Chron's disease	☐	Low Back Pain	☐	Mid Back Pain
☐	Arthritis	☐	Numbness/Tingling	☐	Migraine Headaches	☐	Shoulder / Arm Pain
☐	Asthma	☐	Hearing Impaired	☐	Fibromyalgia	☐	Pregnancy (Current)
☐	Leg Pain ___________	☐	Visually Impaired	☐	Dizziness / Fainting	☐	Broken /Fractured Bones
☐	Cancer ___________	☐	Diabetes	☐	Sprains / Strains	☐	Epilepsy / Seizures
☐	Headaches	☐	Drug Use _____________	☐	Chest, ribs, abdominal pain	☐	Problems walking
☐	Jaw pain TMJ	☐	Alcohol Use ____________	☐	Osteoporosis	☐	Scoliosis
☐	Swollen ankles	☐	Nicotine Use ___________	☐	Varicose Veins	☐	Blood Clots
☐	Stroke	☐	Infectious Disease (please list)	☐	Heart Conditions	☐	Allergies
☐	Sinus Problems		_____________________	☐	Lymphedema	☐	Rashes
☐	Athletes Foot		_____________________	☐	Herpes/shingles	☐	Constipation
☐	Head Injury (Concussion)		_____________________	☐	Rashes / Skin irritations	☐	Other _____________

Please indicate any areas of pain / stiffness that you are currently experiencing.



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Client Policy Statement

The Responsibilities of the Massage Therapist are outlined below

- I am a licensed Massage Therapist who will provide therapeutic massage for the purpose of relaxation and pain relief. I will be respectful and professional during our entire relationship.
- I will keep a confidential file of all documents and anything else pertinent to your healing process (Doctor's notes, etc.) Certain forms may be released to the client's doctors and insurance companies.
- All written correspondence, telephone conversations, and conversations that take place during the session are kept completely confidential between the Massage therapist and the client.
- I will not diagnose any medical conditions, for that is not in my scope of practice.
- Should I find concern of medical conditions I will communicate such concerns with the doctor, as well as urge you, the client, to schedule an appointment to address these items.
- The benefits of massage include an increase in circulation of blood and lymph, an increase in metabolism, an increase in the immune system, an increase in muscle tone, improved skin tone and promotion of relaxation.
- Some contraindications that may prevent one from receiving a massage are pathological skin conditions, areas of bleeding, or acute inflammation, recent traumas or accidents, and cancer.
- I respect your time and will be prepared to begin the session at the scheduled time.

The Responsibilities of the Client are outlined below

- The client is responsible for providing the therapist with current medical information and updating this each and every time something has changed. This information is extremely important.
- If you have medical conditions of concern or symptoms outside my scope of practice as massage therapist, you are urged to schedule an appointment with the doctor.
- Sexual innuendos, language, and behavior will not be tolerated. The session will be ended immediately and the client will be charged full price if such an occurrence takes place.
- Payment is due at the end of the session and will be taken by the front desk.
- Sessions will begin and end **at the scheduled times.**
- _______ **CANCELLATIONS** – the client will have **24 hours before the scheduled session** in which they can cancel at no charge. If the client has not called to cancel the appointment or fails to show, they will be charged the **full amount** of the session ($60.00)
- There is a $25.00 fee for all returned checks.
- The client will be clean and showered prior to the session.
- The client will not show up to the session under the influence of drugs or alcohol.

I HAVE READ THE ABOVE STATEMENTS AND FULLY UNDERSTAND THEM.

_________________________________ _____________________________

Patient Signature Date