CHIRO CARE ASSOCIATES

MASSAGE INTAKE FORM

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	❑ MR. ❑ MS. ❑ DR.	❑ MRS. ❑ MISS.	MARITAL STATUS (PLEASE CHECK) ❑ S ❑ M ❑ D ❑ W
HOME PHONE #: ( )	CELL PHONE #: ( )	BIRTH DATE: / /		AGE:	GENDER:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:	EMAIL ADDRESS:	
OCCUPATION:	EMPLOYER:	WORK PHONE #: ( ) EXT.			
EMPLOYER STREET ADDRESS:	CITY:	STATE:	ZIP CODE:		
NAME OF YOUR PRIMARY CARE PHYSICIAN:	ADDRESS:	OFFICE PHONE #: ( )			

CANCELLATION POLICY

PLEASE ALLOW A 24 HOUR NOTICE IF YOU NEED TO CANCEL AN APPOINTMENT, OTHERWISE YOU WILL BE RESPONSIBLE FOR ½ THE COST OF THE ORIGINAL APPOINTMENT SCHEDULED.

PLEASE CHECK ANY HEALTH CONDITION(S) YOU HAVE EXPERIENCED

☐ HEART DISEASE	☐ ARTHRITIS	☐ ALLERGIES	☐ CANCER
☐ DIABETES	☐ HYPERTENSION	☐ HIGH CHOLESTEROL	☐ SKIN CONDITION(S)
☐ RECENT SURGERIES	☐ CARDIOVASCULAR DISEASE	☐ OSTEOPOROSIS	☐ CURRENT FLU / INFECTION
☐ VARICOSE VEINS	☐ BLEEDING DISORDERS	☐ LOSS OF SENSATION	☐ RECENT HOSPITALIZATION
☐ OTHER:			

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE :	RELATIONSHIP TO PATIENT:	HOME PHONE #: ( )	WORK PHONE #: ( )

PLEASE MARK ANY AREA OF PAIN / DISCONFORT