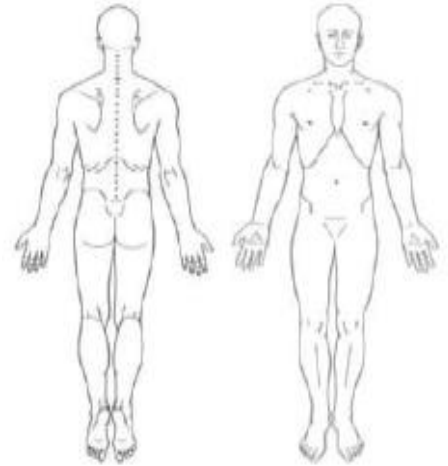


### PRIMARY COMPLAINT

Reason for visit \_\_\_\_\_  
When did symptoms appear? \_\_\_\_\_  
Is condition getting progressively worse?  YES  NO  Unknown  
Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe) \_\_\_\_\_  
Please mark on picture at right to show where your discomfort is.  
Type of pain:  Sharp  Dull  Throbbing  Numbness  Other \_\_\_\_\_  
Time of day it is worse  AM  PM What % of day in pain \_\_\_\_\_  
Does it interfere with  Work  Sleep  Recreation  Daily Routine \_\_\_\_\_?  
Is there anything you do that relieves the pain? \_\_\_\_\_  
What makes the symptoms worse? \_\_\_\_\_



### Notes

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### Consent for Care

Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal during the entire session.

Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I \_\_\_\_\_ (**print name**) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapist are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions. I affirm that I have stated all known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

**Approval of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Approval of Massage Therapist** \_\_\_\_\_ **Date** \_\_\_\_\_

# LiveWell Chiropractic & Wellness

## NEW MESSAGE PATIENT INTAKE

### PATIENT INFORMATION

Date \_\_\_\_\_  
Patient \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex:  M  F Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Single  Married  Divorced  Widowed  Separated  
Whom may we thank for referring you? \_\_\_\_\_  
\_\_\_\_\_

### PHONE NUMBERS

Home \_\_\_\_\_ Cell \_\_\_\_\_  
Work \_\_\_\_\_  
Email \_\_\_\_\_  
Best time/place to contact you  AM  PM  Home  Cell  
In case of emergency, contact:  
Name \_\_\_\_\_ Phone \_\_\_\_\_

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

### Date of Initial Visit

1. Do you have any difficulty lying on your front, back or side? \_\_\_\_\_ If yes please explain:  
\_\_\_\_\_
2. Do you have any allergies to perfume, oils, lotions, or ointments? \_\_\_\_\_ If yes please explain:  
\_\_\_\_\_
3. Are you wearing contact lenses  dentures  a hearing aid  ?
4. Do you sit for long hours at a workstation , computer , or driving  ?
5. Do you perform any repetitive movement in your work, sports, or hobby? \_\_\_\_\_ If yes, please describe:  
\_\_\_\_\_
6. On a scale of 1 – 10, what is your daily stress level? \_\_\_\_\_
7. Do you have any particular goals in mind for this massage session? \_\_\_\_\_ If yes, please explain:  
\_\_\_\_\_

### Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

1. Are you currently under medical supervision for any specific condition? \_\_\_\_\_ If yes, please explain:  
\_\_\_\_\_
2. Do you see a chiropractor? \_\_\_\_\_ If yes, how often? \_\_\_\_\_
3. Are you currently taking any medication? \_\_\_\_\_ If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Please check any condition listed below that applies to you:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Contagious skin condition | <input type="checkbox"/> Allergies/sensitivity      | <input type="checkbox"/> Cancer                                     |
| <input type="checkbox"/> Open sores or wounds      | <input type="checkbox"/> Heart condition            | <input type="checkbox"/> Diabetes                                   |
| <input type="checkbox"/> Easy bruising             | <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Decreased sensation                        |
| <input type="checkbox"/> Recent accident or injury | <input type="checkbox"/> Circulatory disorder       | <input type="checkbox"/> Back/neck problems                         |
| <input type="checkbox"/> Recent fracture           | <input type="checkbox"/> Varicose veins             | <input type="checkbox"/> Fibromyalgia                               |
| <input type="checkbox"/> Recent surgery            | <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> TMJ  |
| <input type="checkbox"/> Artificial joint          | <input type="checkbox"/> Type _____                 | <input type="checkbox"/> Carpal tunnel syndrome                     |
| <input type="checkbox"/> _____                     | <input type="checkbox"/> Osteoporosis               | <input type="checkbox"/> Tennis elbow                               |
| <input type="checkbox"/> Sprains/strains           | <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Pregnancy if yes, how many<br>Months _____ |
| <input type="checkbox"/> Current fever             | <input type="checkbox"/> Headaches/migraines        |   |
| <input type="checkbox"/> Insomnia                  |   |   |