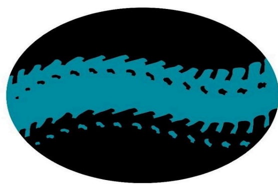


HANOVER CHIROPRACTIC & MASSAGE THERAPY

Patient Intake Form

An accurate health history is important to ensure the safety and effectiveness of massage treatment. All information gathered for this treatment is confidential. Written authorization will be required for release of any information.

Name ____ Date of Birth___________________________

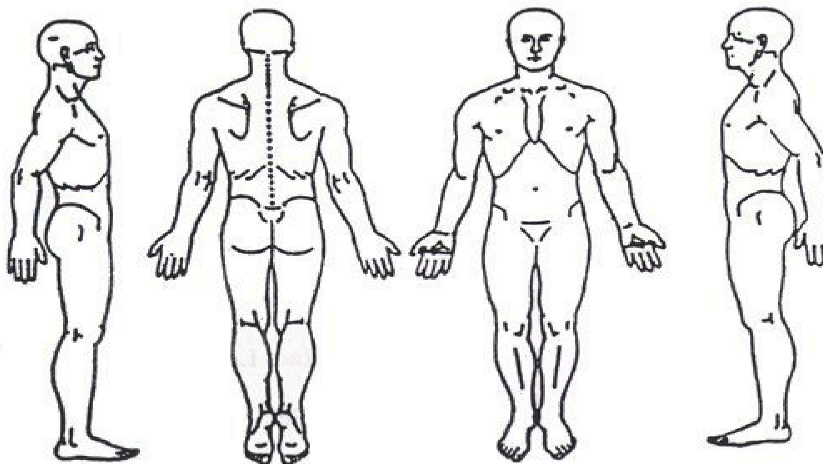
Address ____Phone # __________________________

Gender ______________________________Email ____

Occupation ____

Emergency Contact ______________________ Relationship ________________Phone _________________

PLEASE CIRCLE ANY AREAS OF DISCOMFORT



What are your goals for this treatment session?

( )Relaxation ( )Stress

( )Pain ( )Injury

( )Overall Wellness

( )Other

What is your PRIMARY complaint today?

____

When did it start?____

How did it happen? ____

Have you had a professional massage before? No Yes Last visit:____________________________________

Have you had an x-ray/MRI/CT scan or bloodwork recently or in regards to your primary complaint?

Yes _____ No______

Are you currently pregnant? Yes No

How many weeks? ________________________ Due Date: __________________________________
Any high risk factors? ____
____

Please check any CONDITIONS you currently have or had in past 5 years

( ) Motor Vehicle Accident
( ) Work or Sport Injury
( ) Surgery
Date______ Type_________________
( ) Medical Implants/Joint Replacements
( ) Migraines/Headaches
( ) Diabetes
( ) Cancer
( ) Allergies – mild or severe
( ) Seizures
( ) Family history of: Arthritis, Cardiovascular Disease, Cancer, Stroke, Diabetes

( )Cardiovascular Condition(heart disease, stroke, pacemaker, high blood pressure)
( ) Respiratory condition (asthma, bronchitis, COPD)
( ) Neurological condition (MS, epilepsy, sensory loss)
( ) Mental Health condition (depression, anxiety)
( ) Skin condition (eczema, psoriasis, rash)
( ) Bone or Joint condition (arthritis, fracture, osteoporosis)
( ) Digestive condition (Crohns, heart burn, constipation, IBS)
( ) Smoker
( ) Infectious Disease (hepatitis, HIV, skin infection)

Please list any MEDICATIONS or SUPPLEMENTS you currently use and for what condition:
____
____
____
____

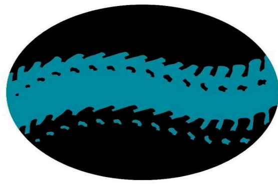
How often are you physically active per week: 0-1 1-2 2-3 3-5 5-7

Additional risks or complications to make us aware of?
____
____
____
____

By signing below, you agree to the following:

I acknowledge and understand that the massage therapist must be fully aware of my existing medical conditions. I have completed my patient intake form as provided and disclosed to the massage therapist all my medical conditions. I understand that it is my responsibility to keep the massage therapist updated on my medical history. The information provided is true and complete to the best of my knowledge. I consent to be assessed by my massage therapist, using a variety of examinations and techniques, for the conditions noted in my health history.

Client Signature ____ *Date* ______________________________



HANOVER
CHIROPRACTIC
& MASSAGE THERAPY

Therapist Signature ___________________________________ *Date* ____________________________