



WELLNESS FROM THE INSIDE OUT

Family and Sports Chiropractic

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MESSAGE INTAKE FORM

In order to maximize the effectiveness and safety of your massage and establish a good Client/Therapist relationship, please take the time to carefully fill out this questionnaire. This information will be treated confidentially (we will not sell or distribute your information for other than a Wellness inquiry). Your feedback after the session is also appreciated to help in tailoring the massage to serve you in the best possible way in your next session to optimize your good health and well-being.

Today's date:		<input type="checkbox"/> If you are currently a patient (disregard the CLIENT INFORMATION)			
Client's Last Name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	DOB: / /
CLIENT INFORMATION					
Street Address:		Email Address:		Home Phone #: ()	
City:	State:	Zip Code:		Cell Phone #: ()	
Referred By:		Occupation:		Employer Phone #: ()	
HEALTH INFORMATION					
Have you ever had a professional massage before?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	If Yes, please explain:	
Your primary reason for a massage today?					
Areas of complaint, pain or tension:					
Are you under the care of a physician?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	If Yes, please list name & number:	
Do you have any medical conditions, symptoms or problems in regard to your health, fitness or any body structure that I should be aware of prior to administering massage therapy? If yes, please describe: _____ _____					
Have you ever broken any bones?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	If Yes, when & where?	
Have you had any operations in your life?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	If Yes, please describe?	
Are you pregnant?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	If Yes, how far along are you?	

CLIENT/THERAPIST RELATIONSHIP STATEMENT & POLICIES

I, _____, understand the massage therapy given here is for the purpose of stress management, reduction of muscular tension, and for increasing circulation and energy flow. I understand that the Massage Therapist does not diagnose illness, disease, or any other physical or mental disorder. The Massage Therapist does not prescribe medical treatment or pharmaceuticals nor do they perform any spinal adjustments. It has been made clear that Massage Therapy IS NOT a substitute for chiropractic or medical attention.

With this in mind, I agree that the Massage Therapist cannot be held liable for any problem that may arise as a result of my massage sessions.

I have stated all my known medical conditions and take it upon myself to keep the Massage Therapist updated on my physical health.

It is also understood that ANY illicit or sexually suggestive remarks or advances made by me, the client, will result in immediate termination of the session, and I will be liable for payment of the entire session.

Promptness for your appointments are greatly appreciated. Please give 24 hour notice of cancellation. Thank you for your courtesy and consideration.

Client Signature _____ Date _____

Therapist Signature _____ Date _____