Bridges Chiropractic Health Clinic

Massage Intake

215 18th ST SE, Owatonna, MN 55060 Phone (507) 451-7580 Fax (507) 451-5387

PATIENT INFORMATION

DATE ___________________________________

____ Nick Name _________________________

First Name MI Last Name

DOB _____________________ ☐ Male ☐ Female

Address: ____

Street City State Zip Code

Phone: ____________________________ ____________________________ ___________________________

Cell Cell Phone **Provider** (i.e. Verizon) Other (Home/Work)

E-Mail: ____

Race: _____________________ Ethnicity ☐ Non-Hispanic ☐ Hispanic/Latino Preferred Language: ________________

Occupation/Employer: ____

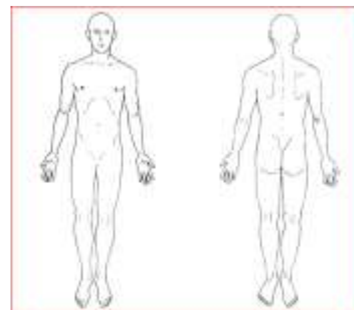
Emergency Contact: ____ Phone: ______________________________

Have you ever had a massage before? __Yes __No

Reason for today's visit: __Decrease Stress __Relaxation __Pain Management __Injury __Other

How would you rate your pain today? (1 =mild 10 = unbearable) **0 1 2 3 4 5 6 7 8 9 10**

Please indicate your areas of pain by drawing an "X" on the diagram: ───────→



Description of Pain, check all that apply:

__Aching __Burning __Cramping __Dull __Numbness __Sharp

__Shooting __Spasm __Stiffness __Throbbing __Tingling

__Other____

Do you have any of the following today? __Sunburn __Open Cuts __Bruises __Skin Rash

Do you have any Allergies to Oils, Nuts or Perfumes? ____

Other Allergies: ____

Are you taking any Medications (Rx or over the counter)? ____

____

Do you have a history of the following?

__Accident: ____________________ __Fibromyalgia __Sciatica

__Arthritis __Headaches __Varicose Veins

__Athlete's Foot __Heart Condition __Warts

__Blood Clots __High Blood Pressure __Whiplash

__Cancer ______________________ __HIV __Other: ___________________

__Diabetes __Jaw Pain (TMJ)

Surgeries and the date: ____

Other Health Concerns:____

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Women only: Are you currently pregnant? __Yes __No Due Date: ___________________

AUTHORIZATION

I CERTIFY that I have read, understand, and provided correct information to the best of my knowledge. I UNDERSTAND that providing wrong information can be dangerous to my health. I UNDERSTAND that this is a therapeutic massage and ANY sexual remarks or advances will IMMEDIATELY TERMINATE the session and I will be liable for payment of the entire scheduled session.

X ____ ____________________________________

Patient Signature Date