Bridges Chiropractic Health Clinic

Massage Intake

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

PATIENT INFORMATION

DATE _____

Patient _____ Preferred Name _____
First Name MI Last Name

Date of Birth _____ ☐ Male ☐ Female Email _____

Address _____
Street City State Zip Code

Cell Ph # _____ Secondary Ph # _____
Other (Home/Work)

Employer _____ Occupation _____

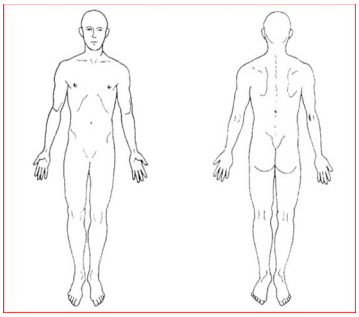
Emergency Contact: _____ Phone: _____

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: _____
__Arthritis
__Athlete's Foot
__Blood Clots
__Cancer _____
__Diabetes
__Fibromyalgia
__Headaches
__Heart Condition
__High Blood Pressure
__HIV
__Jaw Pain (TMJ)
__Sciatica
__Varicose Veins
__Warts
__Whiplash
__Other: _____

Surgeries and the date: _____

Other Health Concerns:_____

_____

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