

**Confidential Case History**  
**Massage Therapy Intake Form**

**Greene Chiropractic Clinic**  
**1507-B Stillwater Ave**  
**Cheyenne, WY 82009**  
**(307) 637-7463**

Date: \_\_\_\_\_

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

e-mail: \_\_\_\_\_ Referred by: \_\_\_\_\_

Occupation: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

**RELEVANT HEALTH HISTORY**

Have you ever received massage therapy?  Yes  No How long since last massage? \_\_\_\_\_

Type of massage experienced (swedish, deep tissue, etc.) \_\_\_\_\_

What kind of pressure do you like?  Light  Medium  Deep  Very Deep  Not sure

Are you allergic to any oils/lotions/aromatherapy? \_\_\_\_\_

Are you currently taking any medications?  Yes  No

If yes, please list name and reason for medications \_\_\_\_\_

Are you currently seeing a healthcare professional?  Yes  No

If yes, please list names and reason/treatment \_\_\_\_\_

Please check all of the conditions you are experiencing now or have experienced in the past:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> allergies              | <input type="checkbox"/> chronic pain        | <input type="checkbox"/> jaw pain (TMJ)       |
| <input type="checkbox"/> arthritis              | <input type="checkbox"/> convulsions         | <input type="checkbox"/> muscle strain/sprain |
| <input type="checkbox"/> asthma                 | <input type="checkbox"/> depression          | <input type="checkbox"/> numbness             |
| <input type="checkbox"/> back problems          | <input type="checkbox"/> dizziness           | <input type="checkbox"/> recent injury        |
| <input type="checkbox"/> blood clots            | <input type="checkbox"/> fatigue             | <input type="checkbox"/> sensitive skin       |
| <input type="checkbox"/> breathing difficulty   | <input type="checkbox"/> fibromyalgia        | <input type="checkbox"/> stroke               |
| <input type="checkbox"/> bruise easily          | <input type="checkbox"/> headaches           | <input type="checkbox"/> surgery              |
| <input type="checkbox"/> cancer                 | <input type="checkbox"/> heart conditions    | <input type="checkbox"/> swollen glands       |
| <input type="checkbox"/> circulatory conditions | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> varicose veins       |

If any of the above needs to be detailed or if there is anything else to share, please do so:

\_\_\_\_\_

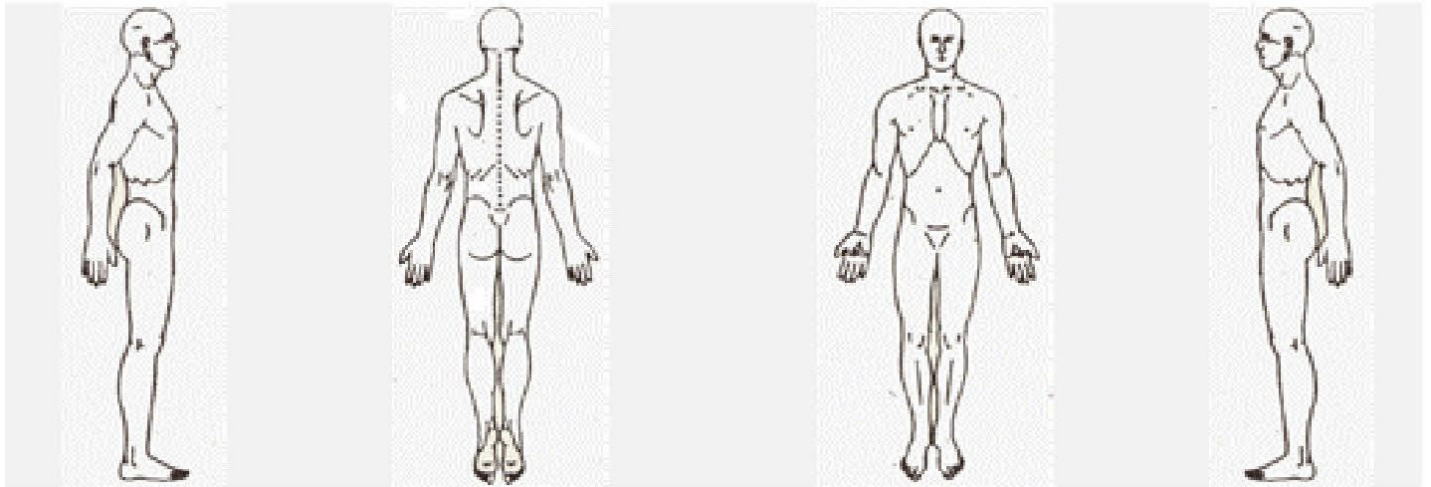
What physical activities do you do? \_\_\_\_\_

Are you pregnant?  Yes  No If yes, date due: \_\_\_\_\_

Do you have any of the following today:  skin rash  cold/flu  open cuts  severe pain  
 anything contagious  injuries/bruises

Are you wearing:  contact lenses  hearing aid  hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session? \_\_\_\_\_

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:  
\*need to move or change position \*sighing, yawning, change in breathing \*stomach gurgling \*emotional feelings and/or expression  
\*movement of intestinal gas \*energy shifts \*falling asleep \*memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_