Wolf Chiropractic, Inc.
1408 Lexington Ave. Suite C
Mansfield, Ohio 44907
(419) 756-6262

Massage Therapy Intake Form

Date: ____ /____ /_____ Name:_____

Date of Birth:____ /____ /_____ Social Security Number: _____-____-_____

Street Address:_____ City:_____ State: ___ Zip:_____

Home Phone #:(_____) _____-_____ Work#:(_____) _____-_____ Cell#:(_____) _____-_____

Occupation:_____ Referred by: _____

Have You Ever Received Massage Therapy: ☐ YES ☐ NO

Type of Massage Experienced: ☐ Deep Tissue ☐ Swedish ☐ Other _____

Are You Taking Medication: ☐ YES ☐ NO If So, Describe:_____

_____

Have You Consumed Alcohol in the Past 24 Hours? ☐ YES ☐ NO

Do You Have a History of the Following? (Please check all that apply)

☐ Accident	☐ Sprains	☐ Fibromyalgia	☐ Neck Pain
☐ Seizures	☐ Whiplash	☐ Abdominal Pain	☐ Diabetes
☐ Headaches	☐ Nervous Tension	☐ Varicose Veins	☐ Disk Problems
☐ Arthritis/Bursitis	☐ Mid Back Pain	☐ Low Back Pain	☐ Joint Ache
☐ High Blood Pressure	☐ Stroke	☐ Heart Attack	☐ Cancer
☐ Allergies (Oils, etc.	☐ Wear Prosthesis	☐ HIV	☐ Surgery
☐ Broken Bones	☐ Wear Contacts	☐ Decreased Range of Motion	☐ Colitis

Do You Have Any of the Following Today?

☐ Sunburn	☐ Inflammation	☐ Open Cuts/Bruises/Burns	☐ Severe Pain
☐ Poison Ivy	☐ Headache	☐ Irritated Skin/Rash	☐ Cold/Flu

☐ Other: Explain _____

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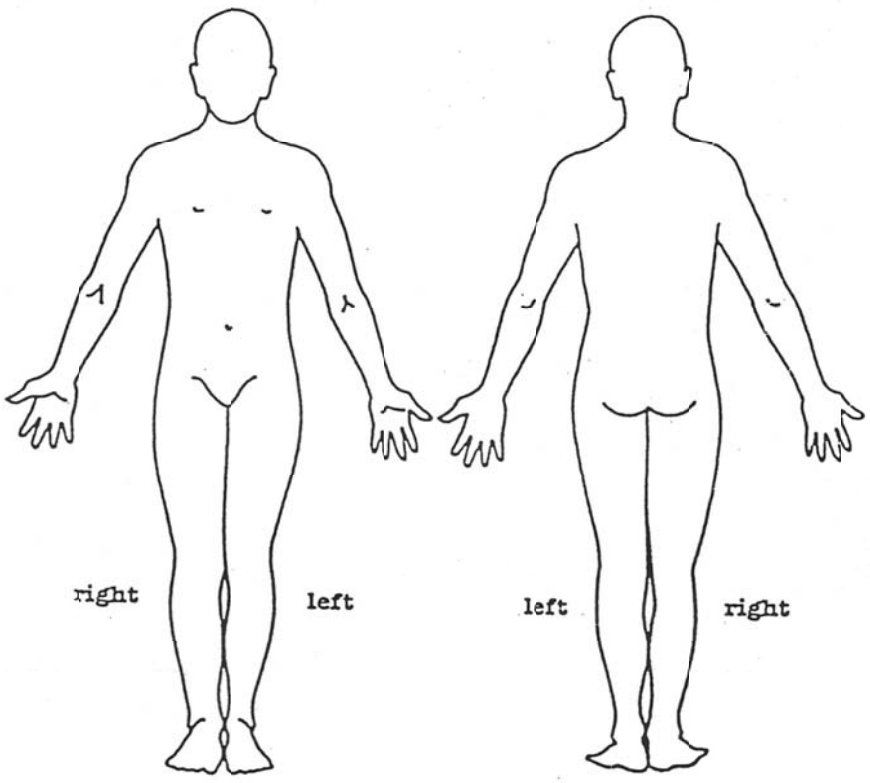
Indicate with an "X" where it hurts most, "O" for mild pain



CLIENT AGREEMENT

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension, or therapeutic applications. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.

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(s) given should be construed as such.

Because massage/bodywork is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the "full" scheduled appointment.

Signed: _____ Date: _____

Practitioner: _____ Date: _____