Massage Intake Form

Name:	Birthdate:
Street Address:	City/State/Zip
Medication(s) you now take:	Mobile phone#
Occupation:	

You are here today for:

_____ Relaxation

_____ Injury/Accident

_____ Specific Complaint

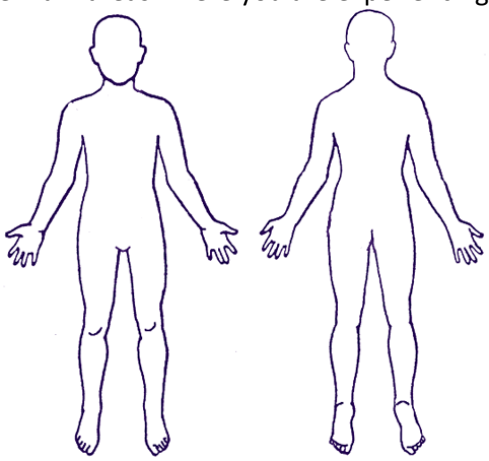
Describe:

_____

_____

_____

Please mark areas where you are experiencing pain:



Front Back

Do you have or have you had any of the following? Please circle

Cancer	High Blood Pressure	Muscle Spasms
Type:	Chronic Bowel Issue	Osteoporosis
Year diagnosed:	Diabetes	Heart Problems
In remission: Yes No	Liver Disease	Blood Clots
Currently receiving radiation/chemo Yes No	Recent surgery Type:	Herniated Discs Discectomy
Oncologist's Name:	Broken bones where	Fused discs Allergies
Oncologist's Phone #	Numbness where	Recent accident/fall

Any other condition(s) you've been diagnosed with that are not mentioned above?

I agree that I have listed all known medical conditions. I release all employees of Hatch Chiropractic and Wellness from any and all liability if I fail to inform them of any health changes or of any known health conditions or diagnoses.

_____ _____

Signature Date