HATCHCHIRO
REDEFINING HEALTHCARE

Massage Intake Form

Name	DOB
Address	City/State/Zip
Medications	
Cell Phone	Occupation
Email (internal use only)	

You are here today for:

_____ Relaxation

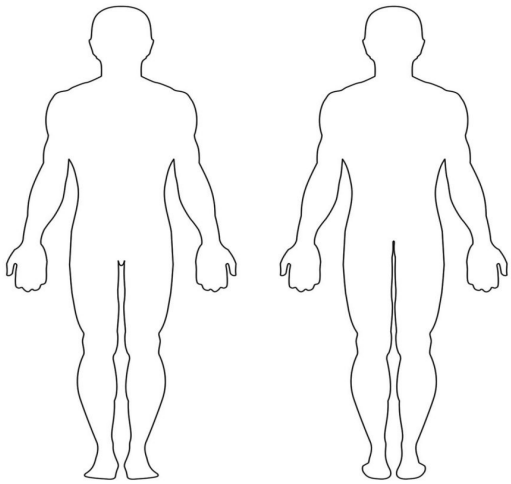
_____ Injury/Accident

_____ Specific Complaint

Describe: _____

_____

_____



Front Back

Do you have any of the following? Please circle.

Cancer If yes:

Type

Year Diagnosed

In Remission □ Yes □ No

Currently Receiving:

Radiation □ Yes □ No

Chemo □ Yes □ No

Oncologist _____

Phone _____

High Blood Pressure
Chronic Bowel Issues
Diabetes
Liver Disease
Muscle Spasms
Osteoporosis
Recent Surgery _____
Type _____
Broken Bones _____
Where _____
Numbness _____

Heart Problems
Blood Clots
Herniated Discs
Where _____
Disectomy
Where _____
Fused Discs
Where _____
Allergies
What _____
Recent Accident or Fall

Do you have any of the following? Please circle.

I acknowledge that I have listed all known medical conditions. I release all providers of Hatch Chiropractic 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