Babich Chiropractic

10618 SE Kent-Kangley Road, Suite 104
Kent, WA 98030
Phone (253) 859-LIFE (5433) Fax (253) 859-4887

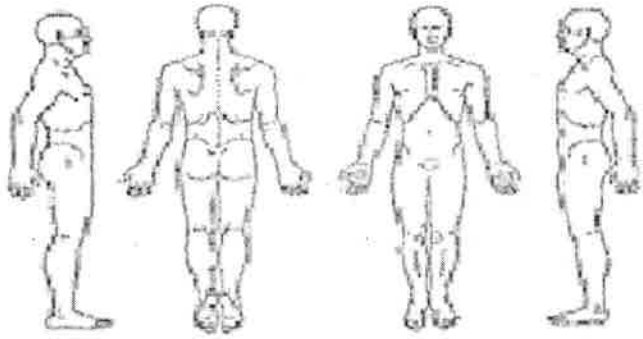
Massage Intake Form

Name _____ email _____
Phone (Cell) _____ Phone (Home) _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Occupation _____
Referred by _____
Emergency Contact _____ Phone _____

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No
   If yes, how often do you receive massage therapy? _____
2. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain _____
3. Do you have any allergies to oils, lotions, or ointments? Yes No
   If yes, please explain _____
4. Do you have sensitive skin? Yes No
5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( )?
6. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please describe _____
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please describe _____
8. Do you experience stress in your work, family, or other aspect of your life? Yes No
   If yes, how do you think it has affected your health?
   Muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?
   Yes No If yes, please identify _____
10. Do you have any particular goals in mind for this massage session? Yes No
    If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session



Medical History

In order to plan a massage session that is safe and effective, please answer the following.

11. Are you currently under medical supervision? Yes No
    If yes, please explain _____
12. Do you see a chiropractor? Yes No If yes, how often? _____
13. Have you had recent surgery? Yes No If yes, please explain _____
14. Do you experience any tingling, numbness and/or stabbing pain? Yes No
15. Have you sustained a neck or back injury? Yes No Date: _____
16. Are you currently taking any medication? Yes No
    If yes, please list _____
17. Please circle any condition listed below that applies to you:

Y / N contagious skin condition	**Y / N** phlebitis	**Y / N** cancer
Y / N open sores or wounds	**Y / N** deep vein thrombosis/blood clots	**Y / N** headaches/migraines
Y / N easy bruising	**Y / N** osteoporosis	**Y/ N** diabetes
Y / N recent accident or injury	**Y / N** epilepsy	**Y / N** atherosclerosis
Y / N recent surgery	**Y / N** tennis elbow	**Y / N** decreased sensation
Y / N artificial joint	**Y / N** carpal tunnel syndrome	**Y / N** Fibromyalgia
Y / N sprains/strains	**Y / N** back/neck problems	**Y / N** TMJ
Y / N current fever	**Y / N** varicose veins	**Y / N** circulatory disorder
Y / N swollen glands	**Y / N** high or low blood pressure	**Y / N** heart condition
Y / N allergies/sensitivity	**Y / N** joint disorder/rheumatoid arthritis /osteoarthritis/tendonitis	

    Please explain any condition that you have marked above _____
    _____
18. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____
    _____
19. **For women only:** Are you pregnant? Yes No
    If yes, how many months? _____ Due Date: _____

Please read carefully and sign below

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this massage session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see 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 given should be construed as such. Because massage should not be performed 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

I have been informed that the therapist has the right to refuse service to anyone and will not provide massage anyone under the influence of alcohol or drugs, I also understand that it is my right as the client to terminate the session at any time if I am uncomfortable for any reason.

I agree to phone if I will be late for my appointment, understanding that I will receive only the amount of time remaining in my scheduled time slot. I understand there is a 24-hour notice for cancellation and in the event this is not possible I am responsible for a $50 fee.

Signature of client _____ Date _____