



REGIONAL CHIROPRACTIC CENTER

L A K E N O R M A N

736 Brawley School Road • Suite E • Mooresville, NC 28117
Office: 704-664-1031 • Fax: 704-664-1035 • www.regionalcc.com

Massage Intake Form

Personal Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Home: _____ Work: _____ Cell: _____

Occupation: _____ Email Address: _____

Who referred you for treatment? _____

Credit Card # _____ Exp: _____ CV#: _____

We keep credit card information on file to hold your appointment. If appointment is cancelled without a 24 hour notice we will charge the card for that missed appointment.

Additional Information:

What is the PRIMARY complaint that brings you in for treatment today? _____

Any secondary complaints you would like to address today? _____

Would you like me to focus on or stay away from any specific area? _____



REGIONAL CHIROPRACTIC CENTER

L A K E N O R M A N

736 Brawley School Road • Suite E • Mooresville, NC 28117
Office: 704-664-1031 • Fax: 704-664-1035 • www.regionalcc.com

Please check any of the conditions you've had in the past or currently have:

- | | | |
|--|---|---|
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Neurological Condition | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis (Osteo/Rheum) | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Asthma/Difficulty Breathing | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Digestive Issues |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Diabetes (Type 1 or 2) | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Chronic Infections | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Tension/Stress |
| <input type="checkbox"/> Muscle/Joint Pain | <input type="checkbox"/> Rash/Skin Conditions | <input type="checkbox"/> Back/Neck Pain |
| <input type="checkbox"/> Eyestrain/Irritation | <input type="checkbox"/> Chest Pain/Tightness | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Menstrual Issues | <input type="checkbox"/> Earaches/Ringing in Ears | <input type="checkbox"/> TMJ/Jaw Pain |

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE AND TRUE. IF MY MEDICAL/HEALTH STATUS SHOULD CHANGE, I WILL INFORM MY THERAPIST IMMEDIATELY.

I understand myofascial release/bodywork may be contraindicated. I also understand that 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 is beyond the scope of practice of my massage therapist. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness. Because myofascial release/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and have answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand there should be no liability on the part of the therapist should I forget to do so. It is also my understanding 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 full payment of the scheduled appointment. I understand I will be charged for appointments I cancel or miss without 24 hours notice of my scheduled appointment. I also understand that if I arrive late I will receive the remainder of the time scheduled, but will be liable for payment in full.

Client Signature: _____

Date: _____

Parent/Guardian Print: _____

Parent/Guardian Signature: _____