KIRSCHNER
Chiropractic & Wellness Centre

Kirschner Chiropractic & Wellness Centre / Arcadia Chiropractic Clinic

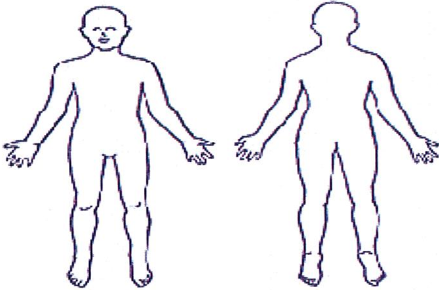
Massage Intake

Today's Date:____/_____/______ Patient Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr.
First Name______________________ Nick Name______________________
Last Name ______________________ Middle Name ______________SSN ______________
Address 1 ____
City______________________ State______________ Zip Code ______________
Primary Phone ______________Secondary Phone ______________Mobile Phone ______________
Home email ______________________ Work Email ______________________
Health Insurance Carrier:______________________ Policy Number:______________________
*Policy Holder:*______________________ *DOB:*______________ *SSN:*______________

Contact Method: ❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth: _____/_____/_____Age:_______Gender: ❑ Male ❑ Female ❑ Unspecified **Marital Status:** ❑ Single ❑ Married ❑ Other
Do you have Children? ❑Yes ❑NO **Employment Status** *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed **Business Name:**______________________ Title/Occupation:______________
Whom can we thank for referring you to our office?:______________________

PLEASE CIRCLE YOUR AREAS OF PAIN



Have you ever experienced a massage? ❑Yes ❑No
How recently? ______________________
What did you like about it?
____
What didn't you like about it?
____

Nature of you Injury
On A Scale of 1 (low) to 10 (Severe) please rate your PAIN LEVEL today:______________________

←Circle the areas of concern for today's treatment.
←Please indicate any area of pain, tingling, tightness or spasms with an 'X'

Do you have numbness or tingling in any specific area?
❑Yes ❑No
How do you prefer the pressure to be?
❑Light ❑Moderate ❑Deep
What is your height: ______________________
What is your Weight: ______________________
Areas to Avoid:______________________
Areas for Additional Therapy:______________________

Race: ❑ White ❑ Black/African American ❑ Hispanic ❑Other______________ ❑ I choose not to specify
Multi-Racial: ❑Yes ❑No ❑ Unknown **Ethnicity** *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify
Preferred Language: ❑ English ❑ Spanish ❑ I choose not to specify
Do you currently smoke/ chew tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker
Current medications, including frequency and dosage if known:______________________
If there are no current medications, check here: ❑
List any known allergies you have had to any medications:______________________
If no allergies are known, check here: ❑
Briefly list your main health problems: ______________________
Do you have any difficulty lying on your front, back or side? ❑Yes ❑No
If yes, please explain:______________________
Do you have any particular goals in mind for this massage session? ❑Yes ❑No
If yes, please explain: ______________________

Patient Name:______________________ Patient/ Gaurdian Signature:______________________ Date:________

By signing above the patient or parent/ guardian, hereby authorizes a Licensed Massage Therapist to administer massage or bodywork therapy techniques as necessary on the above named patient.