

# Tigges Chiropractic and Wellness Massage Therapy Intake Form

(Please print)

Date \_\_\_\_\_

Name \_\_\_\_\_ SS: \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital status  M  S  W  D

Email \_\_\_\_\_ How many children? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Name of spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Patient's Nearest Relative \_\_\_\_\_ Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Referred by: \_\_\_\_\_

Describe your areas of discomfort \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did your discomfort begin? \_\_\_\_\_

How often have you been experiencing discomfort? (Please circle)

- 1) Constantly (76-100% of the day)    2) Frequently ( 51-75% of the day)  
3) Occasionally (26-50% of the day)    4) Intermittently ( 0-25% of the day)

Is your discomfort:  improving     getting worse     same

Indicate the average intensity of your symptoms    None 1 2 3 4 5 6 7 8 9 10 Unbearable

How much has pain interfered with your normal work (including both work outside the home, and housework)

- not at all     a little bit     moderately     quite a bit     extremely

During the past 4 weeks how much of the time have your symptoms interfered with your social activities? (visiting with friends, relatives, etc)

- all of the time     most of the time     some of the time     a little of the time     none of the time

In general would you say your overall health right now is....

- excellent     very good     good     fair     poor

Who have you seen for your symptoms?  No one     M.D.     Chiropractor (D.C.)     P.T.

Other \_\_\_\_\_

Names: \_\_\_\_\_

What treatments did you receive? \_\_\_\_\_

# Tigges Chiropractic and Wellness

## Massage Therapy Intake Form Questionnaire

### RELEVANT MEDICAL HISTORY (Check if you have had in the past or present)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy/ Seizures	<input type="checkbox"/> Psychological problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Neck pain or spasms
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hand or wrist pain	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Back pain/Sciatica	<input type="checkbox"/> Headaches	<input type="checkbox"/> Numbness
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems/Stroke/TIA	<input type="checkbox"/> Polio
<input type="checkbox"/> Concussion	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Convulsions	<input type="checkbox"/> High/Low blood pressure	<input type="checkbox"/> Sinus trouble
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Digestion problems	<input type="checkbox"/> Measles/ T.B.	<input type="checkbox"/> Thyroid or menstrual prob.
<input type="checkbox"/> Dizziness	<input type="checkbox"/> M.S./ Muscular dystrophy	<input type="checkbox"/> Venereal diseases

Do you have any skin conditions?  Yes  No If yes, list condition(s): \_\_\_\_\_

Are you pregnant?  Yes  No If yes, how many weeks? \_\_\_\_\_

What operations have you had? \_\_\_\_\_

Serious illnesses \_\_\_\_\_

Family Health History \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

Have you been treated for any health conditions in the past year? \_\_\_\_\_

Have you ever seen a Massage Therapist?  yes  no If yes, who \_\_\_\_\_

Name of personal chiropractor \_\_\_\_\_

Name of personal medical doctor \_\_\_\_\_

I understand that massage therapy involves neither diagnosis nor treatment of any condition as it is not a substitute for medical care. I understand that I am responsible for providing medical information to my massage therapist. All information given before or during sessions will remain confidential. Draping will be used at all times, unless I request optional clothing; no inappropriate areas will be massaged. If I am uncomfortable for any reason I may request to end the session and the session will be ended. Barring an emergency, I understand that 24 hour cancellation is required. Payment is due at time of service, unless other arrangements have been made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_