Tumwater Chiropractic Center
128 D Street
Tumwater WA 98501
(360) 570-9580
Fax (360) 570-9583

MASSAGE THERAPY INITIAL INTAKE

Patient Name: _____ Date of Birth: _____
Last First Middle

Mailing Address: _____ Home Phone: _____
Street

_____ Work Phone: _____
City State Zip

Employer _____ Occupation _____

Emergency Contact _____ Phone Number _____

Is your treatment today related to a car accident or work injury? Y/N If so, indicate date of injury _____

What are your overall goals for massage therapy? _____

_____

Are you currently receiving medical or chiropractic care? Y/N Please Explain _____

_____

Please list all prescription and non-prescription medications taken within the last 6 months. Please indicate dosage.

_____

_____

Have you ever experienced any of the following conditions? **Please use 'C' for Current; 'P' for Past.**

____ Aids
____ Allergies
____ Anemia
____ Arthritis
____ Back Pain
____ Broken Bones
____ Bursitis
____ Cancer
____ Chronic Fatigue Syndrome
____ Pregnancy
____ Circulation Problems
____ Colitis
____ Constipations
____ Psoriasis
____ Epilepsy Seizures
____ Fibromyalgia
____ Headaches/Migraines
____ Heart Ailments
____ Hemophilia
____ Sciatica
____ High Blood Pressure
____ Insomnia
____ Low Blood Pressure
____ Inflammation
____ Muscle Spasms
____ Numbness
____ Phlebitis
____ Digestive Problems
____ Skin Allergies
____ Stress
____ Stroke
____ Swollen Feet/Legs
____ Tendonitis
____ Disc Problems
____ Infectious Diseases
____ Tingling
____ TMJ Dysfunction
____ Varicose Veins
____ Whiplash
____ PMS
____ Diarrhea
____ Rashes

Additional Comments _____