ZELLNER
chiropractic center

# Massage Therapy Intake Form

## Personal Information

Name: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: (_____) _____ Evening Phone: (_____) _____

Email Address: _____ DOB: _____

Emergency Contact: _____ Phone: (_____) _____

Do you grant your massage therapist permission to contact you via phone or email regarding special offers, to send you birthday cards, and call to check in with your health? Circle Y N

## Massage Experience

How did you hear about us? _____

Have you ever had a professional massage before? Y / N

If yes, when was your last massage? _____

What type of massage? (ex. Swedish, Deep Tissue, etc) _____

What is your goal for today? _____

What type of pressure do you like? (Please Circle)
Light ---- Medium ---- Firm ---- Deep

Are you *uncomfortable* with any of the following areas to be massaged?
*Gluteal Region (Y/N)* *Chest/Pectoral Region (Y/N)* *Face/Scalp (Y/N)* *Feet (Y/N)*
*Other?* _____

1310 Alpine Avenue | Boulder, Colorado | 80304 | 303-444-7524 | fax: 303-444-2464
info@zellnerchiropractic.com | www.zellnerchiropractic.com

ZELLNER
chiropractic center

## Health History

Please list any medications or supplements you are currently taking and explain:

_____
_____
_____
_____

Please list any injuries/accidents/illnesses still affecting you:

_____
_____
_____
_____

Please list any surgeries and explain:

_____
_____
_____
_____

Please list any other pertinent medical history:

_____
_____
_____
_____

1310 Alpine Avenue | Boulder, Colorado | 80304 | 303-444-7524 | fax: 303-444-2464
info@zellnerchiropractic.com | www.zellnerchiropractic.com