

**Center For Life Chiropractic  
1004 NW Milwaukee Ave. Suite 200  
Bend, OR 97701  
541-312-9794**

**Massage Intake Form**

The information provided is confidential and will not be shared without your permission.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Dr. Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Under any medical treatment?:      Yes      No  
Have you ever had surgery?    Yes      No  
If Yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Have you ever been in an accident?    Yes      No  
If yes, please explain any injuries obtained and when: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medication you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

Blood Pressure:    High      Low      Normal  
Pregnant:    Yes      No  
If Yes, what month? \_\_\_\_\_

Last Name:

Date:

Please indicate on the image where you have pain or discomfort:



Please check if you have or have had any of these conditions:

Allergies  
Anemia  
Anxiety  
Arthritis  
Asthma  
Cancer  
Diabetes  
Edema  
Fatigue  
Headaches  
Migraines

Heart Disease  
Hepatitis  
Herpes  
Nausea  
Numbness / Lack of Sensation  
Osteoporosis  
Painful Menstruation  
Poor Circulation  
Skin Disorders  
Skin Rashes  
Other

Signature: \_\_\_\_\_

If under 18, parent or guardian signature:

\_\_\_\_\_