Last Name:

Date:

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: _____

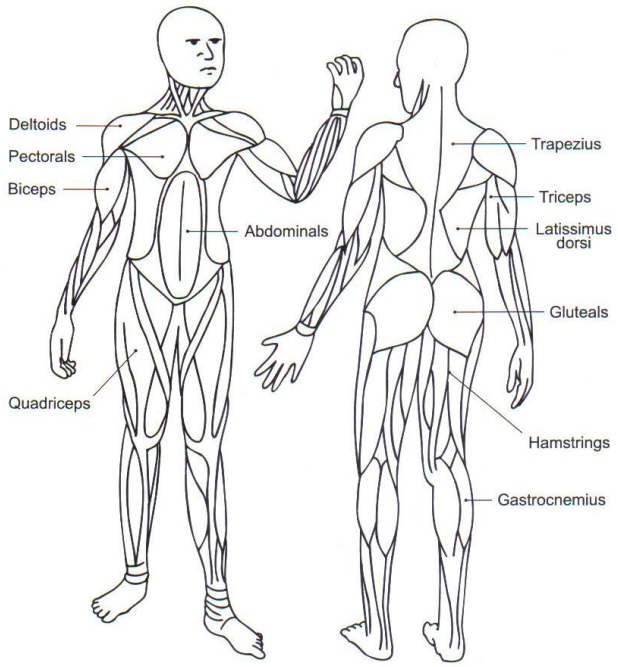
_____

Blood Pressure: High □ Low □ Normal □

Are you pregnant: Yes □ No □

If yes, how many weeks/months? _____

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

If other, please explain:

_____

_____

Signature: _____

If under 18, parent or guardian signature: _____

PLEASE NOTE: We require that you provide 24 hours advance notification of appointment cancellation or changes. Appointments cancelled in less time will be subject to a $25 charge to the client.

_____**Initial**