New York Spine & Wellness Center

Client Intake Form
PERSONAL HEALTH INFORMATION

Name: _____ Date: _____

Date of Birth: _____

Have you ever received a professional massage? _____ If yes, frequency: _____

Date, time, name, and dose of last pain medication: _____

Are you here for?

☐ Stress Management ☐ Injury ☐ Workers compensation injury Date: _____

☐ Chronic Pain Relief ☐ Relaxation

Where is your pain located? _____.

If this is a Workers' compensation case what body areas are covered? _____.

Please note that you may be held accountable for payment if you request massage unrelated to your injury .

Do you have more then one case? _____.

Please indicate below any significant medical problems, as such conditions can influence the type and/or depth of work done in any given area. Thank you.

☐ Are you allergic to any nuts, oils, lotions, etc?

☐ Skin condition (acne, rash, allergies, skin cancer, other)

☐ Recent injury (whiplash, sprain, deep bruise, other)

☐ Circulatory condition (heart disease, varicose veins, phlebitis, arrhythmias, arteriosclerosis, other)

☐ Neurological condition (sciatica, numbness/tingling of any area of skin, stroke, epilepsy, other)

☐ Joint problems, pain, or stiffness (osteoarthritis, rheumatoid arthritis, gout, hyper mobile joints, sacroiliac problems, other)

☐ Bone conditions (osteoporosis, previous fracture, cancer, other)

☐ Headaches (migraines, PMS, tension, cluster, other)

☐ Emotional difficulties (depression, anxiety, psychotic episodes, other)

☐ Stress

☐ Previous surgery, Please state type and date: _____

☐ List any medications you are currently taking: _____

Are you taking any blood thinners? Yes ☐ No ☐

☐ Other (accidents, diabetes, cancer, pregnancy, etc) _____

It is my choice to receive massage therapy. I realize that the treatment is being given for the well being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, increasing circulation and/or energy flow. I agree to communicate with my practitioner any time I feel like my well being is being compromised. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status. Full payment is required prior to the session. The session may be terminated at the discretion of the therapist if the patient's behavior is deemed inappropriate. **24 hour cancellation notice is required. After 2 missed appointments you will not be rescheduled for massage if you have failed to arrive or cancel your appointments. Failure to arrive at your scheduled time will result in a shorter session time, paid at the original session fee.**

Signature_____ Date_____

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Initial Physical Modality Improvement Questionnaire

NAME:		DOB:
DATE:		Date of injury:
Body part(s) covered under this injury:		
Circle visit type	Acupuncture/ Chiropractic/ Massage	
Please answer the following questions.		
1	Please list any difficulties you have walking:	
2	Please list any assistive devices you use to walk, e.g. cane, walker, ect.:	
3	Please list any difficulties you have with bathing/washing yourself:	
4	Please list any difficulties you have while dressing yourself:	
5	Please list house work that is difficult for you to do:	
6	Please list any issues you have with falling asleep or staying asleep:	
7	Please list any areas of your body that do not have full range of motion:	
8	Do you take any medication for pain? If so please list name and does and how many times a day you take it:	
9	Are you currently participating in any strength or aerobic exercise programs?	