Massage Therapy Intake Form

Referred by:_________________

Name: ____
Date of Birth: ____
Home Phone: ( ) __________________ Cell Phone: ( )_______________________
Work Phone: ( ) __________________
E-mail address:____
Address:____
City:___________________State:_______Zip:_________

Have you ever had a professional massage before? _________
If so, how often? ________________ What type(s)? ________________
Do you exercise? _________ Frequency: ___________________________
Please describe what type of exercise: _______________________________________
Other daily activities: ____
Occupation: ____
Primary Care Physician:____
Chiropractor:____
How do you relieve stress or pain? ____

What are the reasons for your visit today? ___________________________________
What are your other health concerns? _______________________________________
Describe any surgeries you have had: _______________________________________
Describe any accidents you have had: _______________________________________
List all conditions currently monitored by a Health Care Provider: _______________
____

Please note all current and previous conditions:

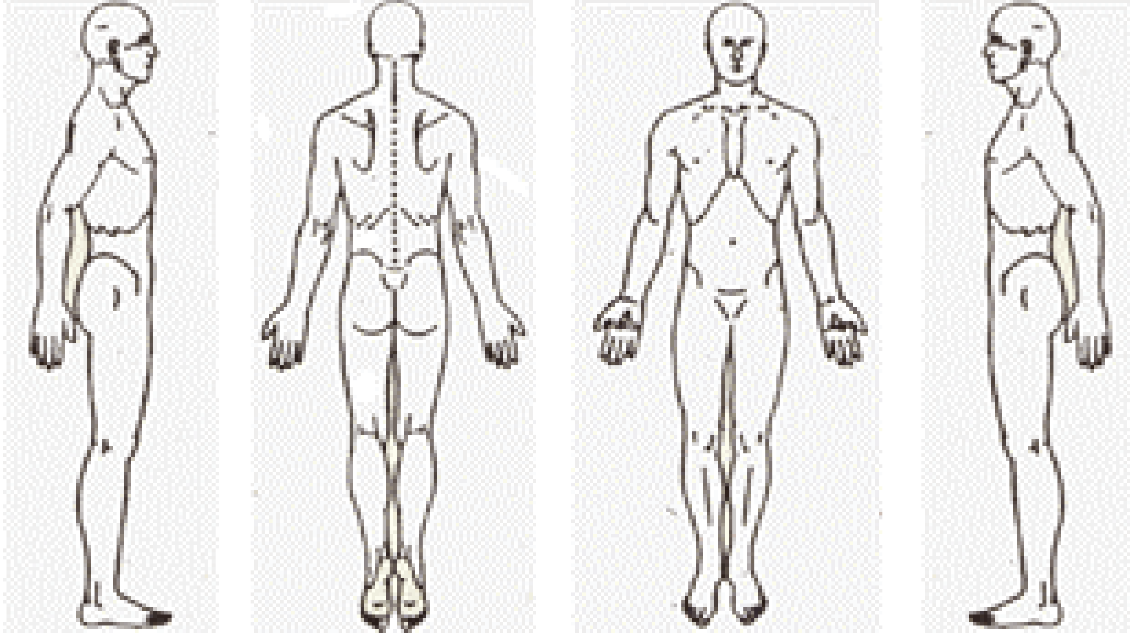
Condition			Condition		
Headache	Y	N	Flu or cold symptoms (last 48 hours)	Y	N
Stiff/painful joints	Y	N	Sciatica	Y	N
Sleep Problems	Y	N	Scoliosis	Y	N
Neck, shoulder, or arm pain	Y	N	Osteoporosis	Y	N
Low back, hip or leg pain	Y	N	Broken bones	Y	N
			Arthritis	Y	N
Numbness (any)	Y	N	Sinus	Y	N
Fatigue	Y	N	Allergies	Y	N
Blood clots	Y	N	Asthma	Y	N
Poor circulation	Y	N	Depression	Y	N
Heart disease	Y	N	Thyroid dysfunction	Y	N
High/low blood pressure	Y	N	Benign - Malignant cancer/tumors	Y	N
Stroke	Y	N	Diabetes	Y	N
Varicose Veins	Y	N	Currently pregnant	Y	N

Describe, as needed, any conditions indicated above, or other conditions that you feel may be important____
____

List any medications that you took today: ___________________________________

Are you wearing: Contact lenses _____ Hearing aid_______ Hairpiece_______

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to; need to move or change position, sighing, yawning, change in breathing, stomach gurgling, emotional feelings and/or expression, movement of intestinal gas, energy shifts, falling asleep, and memories.

Consent

I understand that massage or bodywork is not a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for mental or physical ailments. If I experience pain or discomfort during a session, I will inform the massage therapist so that pressure and area of touch may be adjusted. Because massage therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions. I agree to keep the massage practitioner updated as to any changes in my medical profile. By signing this form, I consent to massage therapy and intend this consent to cover the entire course of my massage therapy treatments. I understand that I may discontinue a session or sessions at anytime. Remember that at anytime during the course of our work together, I cannot make any diagnosis. Any suggestions made during your session are only suggestions. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

I have read the above and consent and understand what it says.

Signature:____Date:_________________

Parent/Guardian (if under 18) :____