Massage Intake Form

CONFIDENTIAL INFORMATION

Welcome! We would like to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your session, please let us know.
Please fill out this form as completely and accurately as possible.

Name_____ D.O.B. _____ Today's Date _____

Home Address_____

City _____ State_____ Zip _____

Main Phone (_____) _____ Please circle: Cell Home Work

E-Mail Address_____ Occupation_____

Whom may we thank for referring you to our office? _____

Have you ever received massage therapy before? Yes No

Types of Massage Experienced? (Swedish, Shiatsu, Deep Tissue, etc.) _____

Currently taking any medications? Yes No If yes, please list names and reason/treatment:_____

_____

_____

Are you currently seeing a healthcare professional? Yes No If yes, reason/treatment: _____

_____

_____

Please review this list and check those conditions that have affected your health either recently or in the past:

__Arthritis
__Broken/Dislocated bones
__Mental / Emotional Disorders
__Diabetes
__Swollen or Painful Joints
__Convulsions / Epilepsy
__Skin Problems
__Bruise Easily
__Cancer
__Allergies
__Frequent Colds
__Upper Back Pain / Stiffness
__Excessive Gas
__Constipation / Diarrhea
__Prostate Problems
__Impotence
__Kidney Problems
__Frequent Urination
__Menstrual Problems / PMS
__Menopausal problems

__Headache
__Migraine Headache
__Neck Pain R/L
__Shoulder Pain R/L
__Numbness or Tingling in arms or hands R/L
__Carpal Tunnel Syndrome R/L
__Dizziness
__Ringing in Ears
__Hearing Loss
__Loss of Balance
__Digestive Problems
__Depression
__Attention Disorder
__Anxiety Disorder
__Eating Disorder
__Trouble Concentrating
__Loss of memory
__Ear Infection
__Learning Disability

__Asthma
__Chest Pain
__Difficult Breathing
__Heart Problems
__Heart Attack
__Stroke
__Bruit
__High / Low Blood Pressure
__Varicose Veins
__Liver Trouble
__Gall Bladder Trouble
__Mid Back Pain / Stiffness
__Pain with cough, or strain
__Hip Pain
__Low Back Pain / Stiffness
__Sciatica
__Numbness or Tingling in legs or feet R/L
__Muscle Tightness
__Trouble sleeping

If any of the above need to be detailed, or if there is anything else to share, please do so: _____

_____

Do you have any of the following today? _____ Skin Rash _____ Cold/Flu _____Open Wounds
_____ Injuries/Bruises _____Severe Pain _____Anything Contagious

Do you have allergies to: _____ Medications _____ Food (Nuts, oils, etc.) _____ Skincare products _____ Environmental (dust, pollen, fragrances, etc.) If you have checked any of the above, please give details: _____

_____

Are you wearing? _____ Contact lenses _____ Hearing aid _____ Hairpiece

Please indicate if any, the areas in which you are feeling discomfort:

Numbness	Pins & Needles	Burning	Aching	Stabbing
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- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
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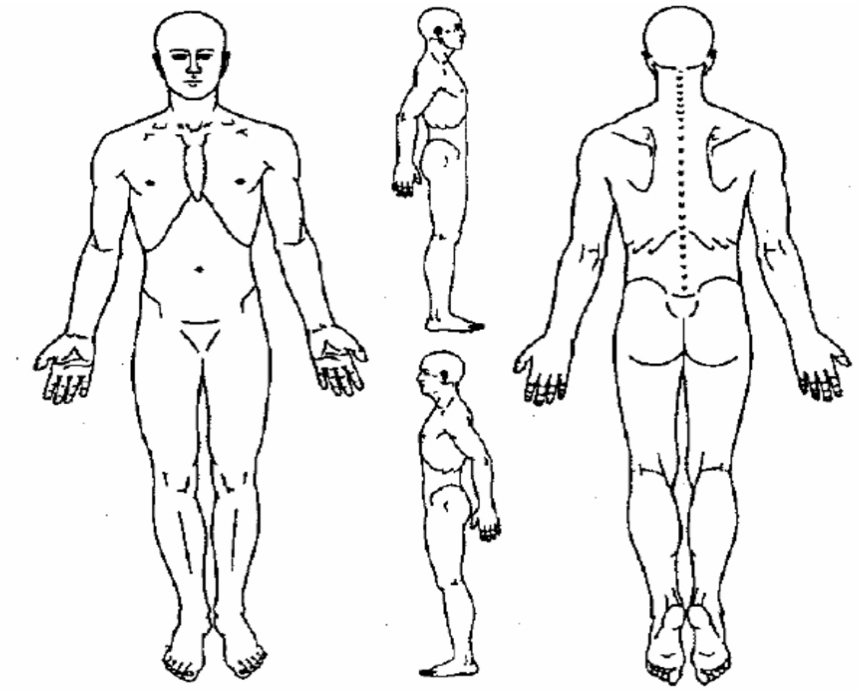

What are your goals/expectations for this therapy session? _____

_____

_____

The following sometimes occur during massage and they are normal responses to relaxation. Trust your body to express what it needs to:

- ♦ need to move or change positions
- ♦ sighing, yawning, change in breathing pattern
- ♦ stomach gurgling
- ♦ emotional feelings and/or expression
- ♦ movement of intestinal gas
- ♦ energy shifts
- ♦ falling asleep
- ♦ memories

Please read the following information and sign below:

1) **I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a subtitute for medical examination, diagnosis and/or treatment.**
2) **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 treament.**
3) **Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully and to the best of my knowledge.**

Signature: _____ **Date:** _____