Massage Intake Form

Confidential

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. Thank you!

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City/ State/ Zip: _____ Cell Phone: _____

Email Address: _____ Cell Provider _____

Would you like Appointment Reminder text Messages sent to your Cell Phone? YES NO

Referred By: _____ Occupation: _____

Have you ever received professional massage therapy? _____ Yes _____ No

Type of Pressure preferred: _____ Light _____ Moderate _____ Deep Tissue

Are you taking any medications? _____ Yes _____ No

If yes, please list name and reason for medications: _____

_____

Please review and check those conditions that have affected your health either recently or in the past. Place a check mark next to the conditions:

___ Arthritis

___ depression, panic disorder, other psych condition

___ Diabetes

___ Diverticulitis

___ Hepatitis (A, B, C, Other)

___ Blood clots

___ Headaches

___ Pregnancy

___ Broken/dislocated bones

___ Heart conditions

___ Skin Conditions

___ Bruise Easily

___ Back Problems

___ Scoliosis

___ Cancer

___ High/ Low blood Pressure

___ Stroke

___ Chronic Pain

___ Spinal Injuries

___ Seizures

___ Constipation/Diarrhea

___ Muscular Disorder

___ Surgery

___ TMJ disorder

___ Chemical Dependency

___Auto- Immune condition*

*AIDS, Lupus, Rheumatoid Arthritis, etc.

___ Vertigo

If any of the above needs to be detailed or if there is anything not listed, please explain: _____

_____

Do you have or had any of the following within the last 5 days:

___ Skin rash ___ cold/ flu ___ open cuts ___ injuries/bruises

___ anything contagious ___ severe pain: _____

Do you have any allergies to:

___medications ___foods (nuts, shellfish, etc.) ___ reactions to skin care products

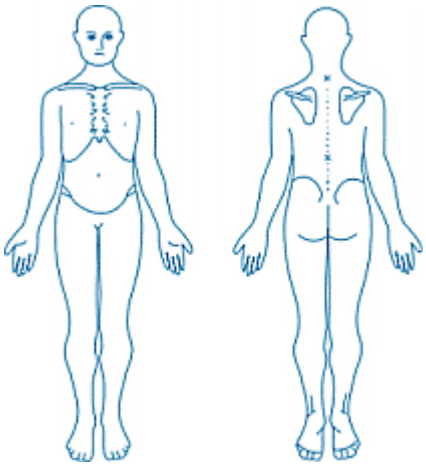
___ environmental allergens (dust, pollen, fragrances)

If any of the above are checked, please provide details: _____

_____

Are you currently wearing: ___ contact lenses ___ hearing aid ___ hairpiece

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



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

_____

Please read the following and sign below:

1. I understand that although massage therapy is very therapeutic, relaxing, and reduces muscular tension, it is not a substitute for medical examination, diagnosis and treatment. Never discontinue use of any medications or treatments without direct consent from your treating physician.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session immediately and I will be liable for full payment of the scheduled treatment.
3. Massage should not be performed under certain medical conditions; therefore, I affirm that I have answered all questions pertaining to medical conditions and treatments thoroughly and truthfully.

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____