MASSAGE INTAKE FORM - CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name _____ Date of birth _____

Address _____ City _____

State _____ Zip _____ Email _____

Phone _____ Occupation _____

Have you ever received massage therapy? ____Yes* ____No *If yes, how often? _____

Type(s) of massage experienced _____

Are you currently taking any medications? ____Yes ____No

If yes, please list name and reason for medications _____

Are you currently seeing a healthcare professional? ____Yes ____No

If yes, please list reason/treatment _____

Exercise routine, if any? _____

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

__ arthritis
__ diabetes
__ blood clots
__ broken/dislocated bones
__ bruise easily
__ cancer
__ chronic pain
__ constipation/diarrhea
__ auto-immune condition
__ hepatitis (A, B, C, other)
__ skin conditions
__ stroke
__ recent surgery
__ TMJ disorder/jaw pain
__ anemia
__ herniated disks
__ neurological problems
__ depression, panic disorder, other psych condition
__ ulcers
__ varicose veins
__ headaches
__ heart conditions
__ back problems
__ high blood pressure
__ insomnia
__ muscle strain/sprain
__ currently pregnant
__ scoliosis
__ seizures
__ whiplash/recent car accident
__ chemical dependency (alcohol, drugs)
__ respiratory problems
__ fainting spells/dizziness
__ muscle cramping

If you have any other medical condition that we should be aware of or you need to elaborate on a condition you checked above, please tell us here:

_____

_____

Do you have any of the following today:

___ skin rash ___ cold/flu ___ open cuts

___ anything contagious ___ severe pain ___ injuries/bruises

Do you have any allergies to:

___ environmental allergens (dust, pollen, fragrances) ___ medications

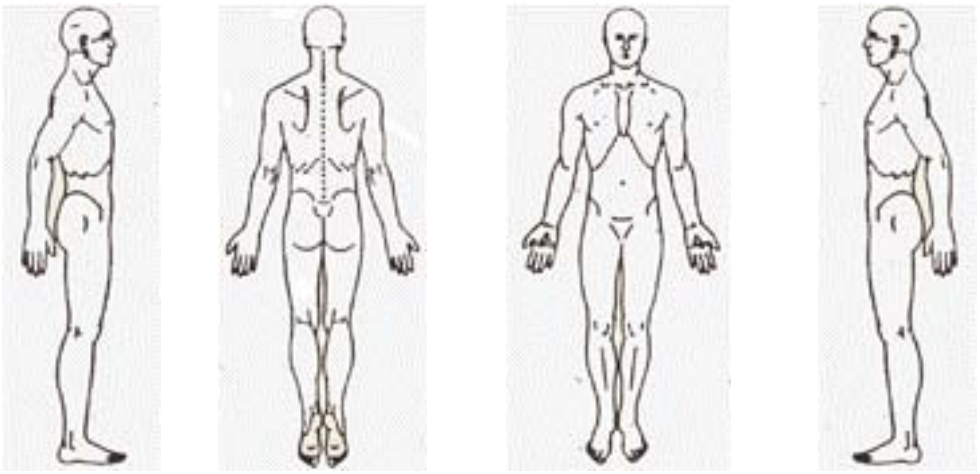
___ reactions to skin care products ___ foods (nuts, etc.)

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

_____

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

Please mark and label the diagram with aches, pains, numbness, or other problems.



X – Stabbing Pain
O – Numbness
//// – Aches
+++ – Pins and Needles
---- – Burning

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

_____

_____

The following sometimes occurs during massage. They are normal responses
to relaxation. Trust your body to express what it needs to:
moving or changing position * sighing, yawning, change in breathing * stomach gurgling
emotional feelings and/or expression * memories * energy shifts * falling asleep

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 substitute for medical examination, diagnosis and 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 treatment.
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.

Signature: _____ Date: _____