Massage Intake

Information for your Massage Therapist.

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition; however, they may play a role in treatment.

General Patient Information

Date: _____ / _____ / _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Would you like to receive our e-mail newsletter? ☐ YES ☐ NO

Age: _____ Date of Birth: _____ / _____ / _____ Place of Birth: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Other

Guardian (if under 18): _____

Gender: ☐ MALE ☐ FEMALE Height: _____ Weight: _____

Occupation: _____ Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Goal from massage or other services we offer: _____

Does anything limit you from care? ☐ NO ☐ YES (explain) _____

How did you hear about our office? _____

Other physicians/therapists seen for this: _____

Please answer the following If you answer yes to any, please explain as clearly as possible:

	YES	NO
Do you frequently suffer from stress?	☐	☐
Do you have diabetes?	☐	☐
Do you experience frequent headaches?	☐	☐
Are you pregnant?	☐	☐

(CONTINUED ON BACK)

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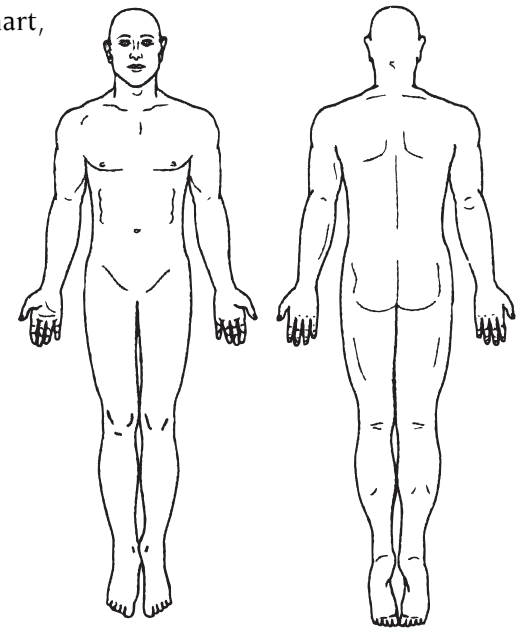
	YES	NO
Do you suffer from arthritis?	☐	☐
Are you wearing contact lenses?	☐	☐
Are you wearing dentures?	☐	☐
Do you have high blood pressure?	☐	☐
If "yes" to previous question, are you taking medicine for this?	☐	☐
Do you suffer from epilepsy or seizures?	☐	☐
Do you suffer from joint swelling?	☐	☐
Do you have varicose veins?	☐	☐
Do you have a contagious disease?	☐	☐
Do you have osteoporosis?	☐	☐
Do you have any allergies?	☐	☐
Do you bruise easily?	☐	☐
Have you had any broken bones in the last 2 years?	☐	☐
Have you been in an accident or suffered any injuries in the past 2 years	☐	☐
Do you have tension or soreness in a specific area?	☐	☐
Please specify: _____		
Do you have cardiac or circulatory problems?	☐	☐
Do you suffer from back pain?	☐	☐
Do you have numbness or stabbing pains anywhere?	☐	☐
Are you sensitive to touch or pressure in any area?	☐	☐
Have you ever had surgery?	☐	☐
Please explain: _____		
Do you have any other medical conditions or are you taking any medications I should know about?	☐	☐
Please explain: _____		

Any other comments? _____

(MORE ON NEXT PAGE)

Please mark painful or distressed areas on the chart, using the following symbols:



X = Pain

> = Swelling

\+ = Tension

– = Weakness

• = Pulsing

I understand that the massage/bodywork I receive is provided for the basic purpose of relocation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medial profile and understand that there shall be no liability on the practitioners part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Consent to treatment of minor: By my signature below, I hereby authorize _____ to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____

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