The Therapy Room 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:_____

Street Address: _____

City:_____ State:_____ Zip Code: _____

Phone:_____ Email :_____

Occupation:_____

How did you find The Therapy Room? _____

Have you ever received massage therapy? _____Yes _____No

Type of massage experienced (Swedish, shiatsu, deep tissue, etc)_____

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 names and reason/treatment

_____

_____

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

____Arthritis ____Depression, panic disorder or other psych. condition

____Diabetes ____High Blood Pressure ____Insomnia

____Blood Clots ____Diverticulitis ____Muscle Strain/Sprain

____Broken/Dislocated Bones ____Headaches ____Pregnancy

____Bruise Easily ____Heart Condition ____Scoliosis

____Cancer ____Back Problems ____Seizures

____Chronic Pain ____Stroke ____Whiplash

____Constipation/Diarrhea ____Surgery ____Chemical Dependency

____Skin Conditions ____TMJ Disorder ____Hepatitis (A, B, C, other)

____Auto-immune Condition (AIDS, Fibromyalgia, chronic fatigue, lupus, etc…)

If any of the listed conditions 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 Cuts ____Severe Pain

____Injuries/Bruises ____Anything contagious

Do you have any allergies to:

____Medications ____Food (nuts, etc.) ____Environmental allergens (dust, pollen, fragrances)

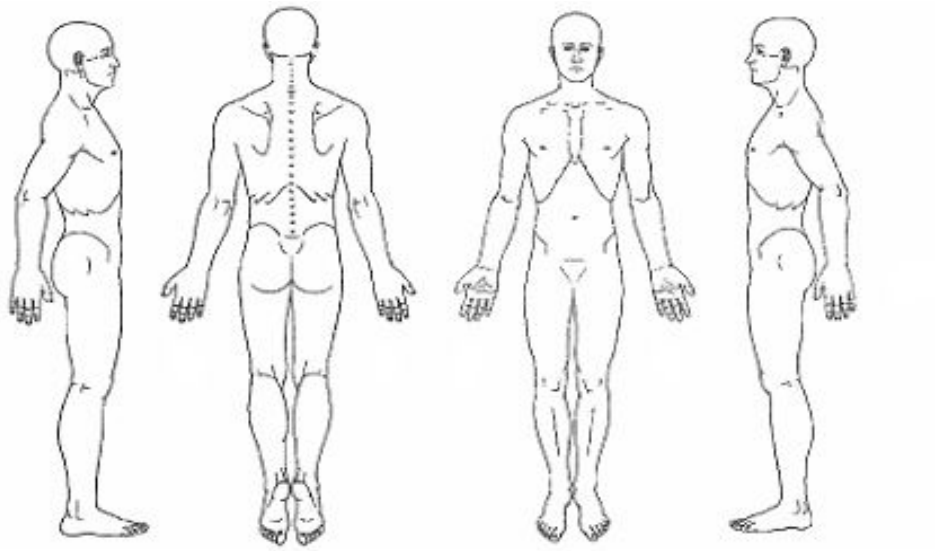
____Skin Care Products

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

_____

Are you wearing: _____Contact Lenses _____Hearing Aid ____Hairpiece

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



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: ~ The need to move or change positions ~ Sighing, yawning, change in breathing ~Falling asleep ~ Stomach gurgling ~ Emotional feelings and/or expression ~ Movement of intestinal gas ~ Energy shifts ~ 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 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: _____