Medical Intake Form

Thank you in advance for filling out this form to ensure your massage is both safe and effective.

Name _____ Preferred Phone Number _____
Birth Date _____ Email _____
Mailing Address _____ City _____ State _____ Zip __
In Case of Emergency _____ Phone _____
Referred By _____
Occupation _____
Common activities _____

Reason for Your Massage: __ Special Ocassion __ Pain Mngmt __ I Love Massage __ Relaxation __ 1st Tim
Massage Session Goal _____ Pressure Preferred __ Light __ Medium __ Firm

__ Yes __ No Are you taking anything for pain relief?
__ Yes __ No Do you have Diabetes?
__ Yes __ No Do you experience frequent headaches?
__ Yes __ No Are you pregnant?
__ Yes __ No Do you suffer from any auto immune conditio
__ Yes __ No Are you wearing contact lenses?
__ Yes __ No Are you wearing dentures?
__ Yes __ No Do you have high blood pressure?
__ Yes __ No Are you taking high blood pressure medicatior
__ Yes __ No Do you suffer from epilepsy or seizures?
__ Yes __ No Are you sensitive to heat on the skin?
__ Yes __ No Do you have varicose veins?
__ Yes __ No Do you have any contagious diseases?
__ Yes __ No Do you have osteoporosis?
__ Yes __ No Do you have any allergies?

__ Yes __ No Do you bruise easily?
__ Yes __ No Any broken bones in the past two years?
__ Yes __ No Any injuries in the past two years?
__ Yes __ No Do you have tension or soreness in a specific area?
Please Specify:
_____
__ Yes __ No Do you have cardiac or circulatory problems?
__ Yes __ No Do you suffer from back pain?
__ Yes __ No Do you have numbness or stabbing pains?
__ Yes __ No Are you sensitive to touch or pressure in any area?
__ Yes __ No Have you ever had surgery? Explain below.
__ Yes __ No Other medical conditions?
Medications _____
Comments:
_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation 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 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 of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjusments, 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 undert 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 medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or

Client Signature _____ Date _____ Therapist _____