Therapeutic Massage Intake Form

Your information will be strictly kept private and confidential.

Name: _____ Date: _____

Birthday:_____ Home Phone #_____

Occupation _____

Home Address: _____

City:_____ State: ____ Zip:_____

Cell Phone Number:_____

Emergency Contact Name/Number: _____

Email Address: _____

May I email you specials and updates every now and then? Y/N

How did you hear about us? _____

Have you had professional massage before? Y/N

If Yes, how often do you receive massage therapy? _____

Please list any allergies _____

Do you sit for long periods of time at computer or driving? Y/N

If Yes, please indicate _____

_____

Do you perform any repetitive movement in work, sport or hobby? Y/N

If Yes, please explain _____

_____

Do you experience stress often in your life? Y/N _____

Effects: ( )Muscle Tension ( )Anxiety ( )Insomnia ( )Irritability

( )Other_____

Please identify particular areas of the body you are experiencing tension, stiffness, pain and other discomforts?_____

_____

What are your goals/intentions for this massage session? _____

_____

Do you do any form of regular cardio exercise or strength training? Y/N

If Yes, please indicate _____

Do you practice yoga, meditation or other forms of internal arts? Y/N

If Yes, what is most helpful to your well-being? _____

List other therapies you currently receive: _____

_____

Clinic Use Only

NOTES

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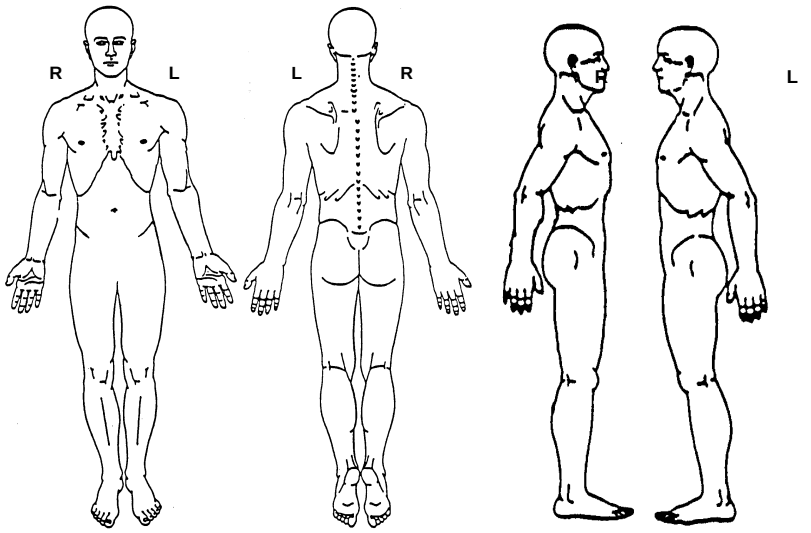
Your information will be strictly kept private and confidential.

Please mark your conditions, areas of concern and/or pain.



Do you have any of the following today:

[ ] Cold or Flu [ ] Are you pregnant? Due:_____

[ ] Open cuts/sores [ ] Skin rash-where:_____

Medical History: Have you ever had/do you have any of the following:

[ ] Diabetes	[ ] High / Low BP: _____	
[ ] AIDS/HIV	[ ] Blood Clot/DVT	[ ] Kidney Disease
[ ] Constipation	[ ] Lupus/ Crohns / Lymes	[ ] Stroke/CVA / TIA
[ ] Fibromyalgia Syndrome	[ ] Liver Disease	[ ] Neuropathy/Numbness
[ ]Chronic Fatigue Syndrome	[ ] Heart Attack/MI	[ ] Seizures
[ ] Cancer/Tumor/Chemo	[ ] Allergies:	[ ] Other

Other: _____

Are you now under medical/therapeutic treatment? Yes / No

If Yes, please explain_____

Please list medications you may be taking: _____

Please list any surgeries you have had: _____

_____

Please list any additional comments regarding your health and well-being: _____

_____

If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 therapists 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature:_____ Date:_____