massage intake form

MASSAGE CLIENT INFORMATION FORM

Name:		Birth Date:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Occupation:	Email Address:	
Primary Care Physician:		Phone:
In case of an emergency, please contact:		Phone:

Who can we thank for referring you to our office: ❑ Newspaper ❑ Mail ❑ Sign ❑ Yellow Pages ❑ Referral_____ ❑ Other_____

MASSAGE HISTORY/SESSION INFORMATION

Have you ever received a professional massage? ❑ Y ❑ N Date of last massage: /

My goal for my massage session today is :

❑ To relax ❑ To get work on a specific area

❑ To help relieve a health concern ❑ To experience a therapeutic massage

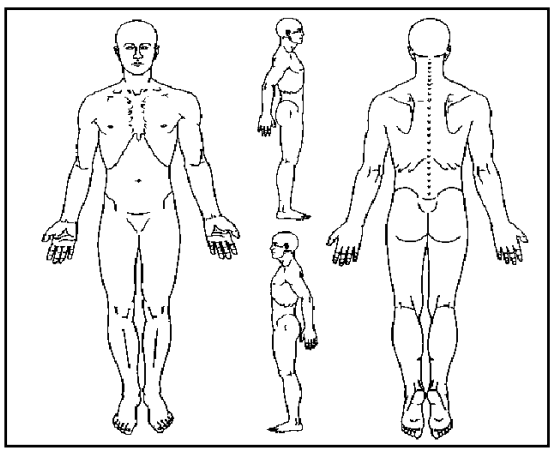
❑ Other:

Are you currently under the care of a health practitioner? ❑ Y ❑ N

If yes, specify purpose:

List current medications and purpose:

I feel the pressure that would best fit my needs would be:
❑ Very/light/light ❑ Medium ❑ Deep/Heavy ❑ I don't know
**The therapist will always work within your tolerance level. It is your responsibility to tell him/her if the pressure is/isn't correct for you.*



Please indicate any area of tension or soreness that you would like to massage therapist to address specifically.

Please circle or "X" the area to the left.

Prioritize ONLY specific problem areas:

_____Neck
_____Legs
_____Hands
_____Upper Back
_____Lower Back
_____Upper Chest
_____Face/Scalp
_____Hip
_____Arms
_____Feet

(1-High Priority, 2-Secondary, 3– If we have time)

ABOUT YOUR HEALTH

The human body is designed to be healthy. At (Practice Name), we are dedicated toward achieving the goal of total lasting health for our members. To better help us achieve this, we need to understand your complete health history. Please help us help you by taking a few moments to answer the following questions.

PRESENT HEALTH CONDITIONS

Please mark any of the following that you now have or have had.

Musculoskeletal

- ❑ Bone or joint disease
- ❑ Tendonitis/Bursitis
- ❑ Arthritis/Gout
- ❑ Jaw Pain (TMJ)
- ❑ Lupus
- ❑ Spinal Problems
- ❑ Other: _____

Circulatory

- ❑ Heart Condition
- ❑ Phlebitis/Varicose Veins
- ❑ Blood Clots
- ❑ High/Low Blood Pressure
- ❑ Lymphedema
- ❑ Thrombosis/Embolism
- ❑ Other: _____

Respiratory

- ❑ Breathing Difficulty/Asthma
- ❑ Emphysema
- ❑ Allergies
- ❑ Sinus Problems
- ❑ Other: _____

Skin

- ❑ Allergies
- ❑ Rashes
- ❑ Athletes foot
- ❑ Herpes/cold sores
- ❑ Other: _____

Nervous System

- ❑ Shingles
- ❑ Numbness/Tingling
- ❑ Pinched Nerve
- ❑ Other: _____

Other

- ❑ Cancer/Tumors
- ❑ Bladder/Kidney ailment
- ❑ Diabetes
- ❑ Drug/alcohol/caffeine/tobacco use
- ❑ Chronic fatigue
- ❑ Chronic pain
- ❑ Sleep disorders
- ❑ Migraines/Headaches
- ❑ Anxiety/Stress Syndrome
- ❑ Depression
- ❑ Contact lenses (hard or soft)

Digestive

- ❑ Irritable Bowel Syndrome
- ❑ Ulcers
- ❑ Other: _____
- ❑ Other: _____

Reproductive

- ❑ Pregnant: Stage_____
- ❑ Ovarian/Menstrual Problems
- ❑ Prostate
- ❑ Other: _____

INFORMED CONSENT

I, _____, (client) understand that massage therapy provided by, _____, (massage therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

_____

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

I have received a copy of the therapist's policies, I understand them and agree to abide by them.

_____ _____

Client Signature Date