Massage Therapy Intake Form

Name:______________________ Date of Birth:______________

Home Phone: ( )______________ Work Phone: ( )______________ Cell Phone: ( )__________

E-mail address:____________________________________

Address:______________________ City:__________ St:______ Zip:______

Referred by:______________________ Have you ever had a professional massage before?______

If so, how often?______________ Do you exercise?__________ Frequency:__________

Please describe what type of excersice____________________________________

Other daily activities:______________________ Occupation:______________

Primary Care Physician:______________________ Chiropractor:______________

How do you relieve stress or pain?____________________________________

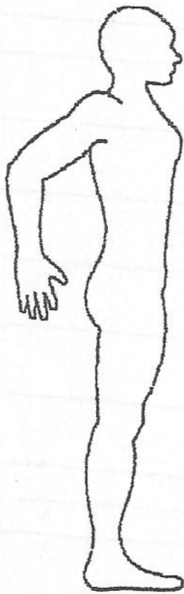
What are the reasons for your visit today?
What are your other health concerns?
Describe any surgeries you have had:
Describe any accidents you have had:
List all conditions currently monitored by a Health Care Provider:
List any medications that you took today:

Please note all current and previous conditions:					
Headache	Y	N	Stiff/painful joints	Y	N
Sleep Problems	Y	N	Neck, shoulder, or arm pain or numbness	Y	N
Fatigue	Y	N	Low back, hip or leg pain or numbness	Y	N
Flu or cold symptoms in the last 48 hours	Y	N	Sciatica	Y	N
Sinus	Y	N	Depression	Y	N
Allergies to scents or lotions	Y	N	Blood clots	Y	N
Allergies, in gereral	Y	N	Stroke	Y	N
Arthritis	Y	N	Heart disease	Y	N
Osteoporosis	Y	N	High/low blood pressure	Y	N
Scoliosis	Y	N	Poor circulation	Y	N
Broken bones	Y	N	Asthma	Y	N
Disc problems	Y	N	Thyroid dysfunction	Y	N
Spasms/cramps	Y	N	Diabetes	Y	N
TMJ (jaw pain)	Y	N	Currently pregnant	Y	N
Tendonitis/bursitis	Y	N	Malignant cancer or tumors	Y	N
Spinal Problems	Y	N	Benign cancer or tumors	Y	N
Varicose Veins	Y	N			

Describe, as needed, any conditions indicated above, or other conditions that you feel may be important

Please use the letters provided in the key to identify the symptoms you are feeling today. Circle the area around each letter, representing the size and shape of each symptom location.

P= pain or tenderness
S= joint or muscle stiffness
N= numbness or tingling



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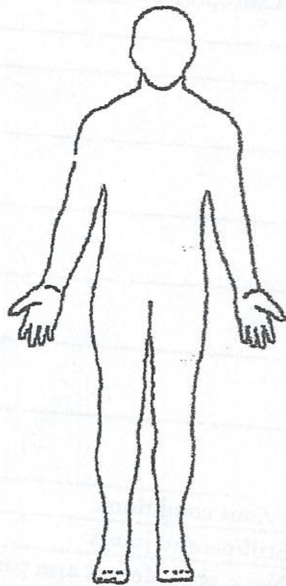
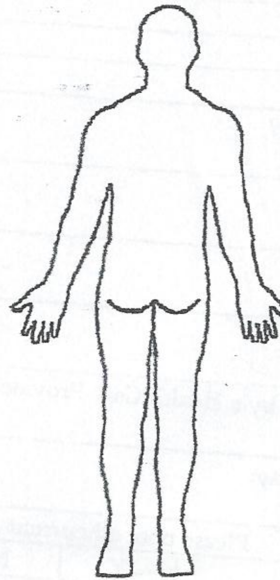
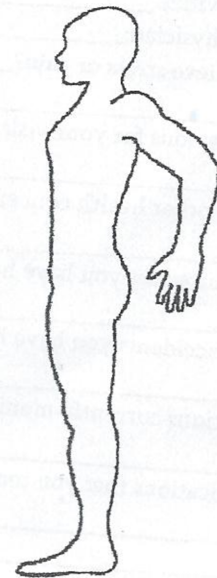


Front



Back



Left

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Client Signature: ______________________________ Date: ____________