Intake Form for Massage Therapy

Name_____ Date_____
Age_____Address_____
City _____Zip Code_____ State_____
Phone_____
Email_____

Brief Health History

Please review this list and check any illness and/or medical conditions which apply.

❑Diabetes	❑Heart condition	❑Ruptured/Bulging disc
❑Skin disorder	❑Varicose veins	❑Cancer
❑Scoliosis	❑Autoimmune disorder	❑Infectious conditions
❑Bruising easily	❑Painful joints	❑ Carpel Tunnel
❑Fibromyalgia	❑High blood pressure	❑Other:_____

Current/Recent illness, injuries, or surgeries? _____
_____

What if any, activities are difficult or painful to do? ___Sitting ___Standing ___Lifting
Other: explain _____
Currently taking any Medications? : ___Aspirin/ Anti-inflammatory:_____ Muscle Relaxants_____ Pain reducers_____ Circulatory Meds._____

Check those you have had in the past six months:

❑ Headaches / Migraines	❑ Numbness in Arms or Hands
❑ Neck Pain	❑ Numbness in Legs or Feet
❑ Tension Across Shoulders	❑ Asthma /Breathing Difficulty
❑ Pain Between Shoulder Blades	❑ Allergies / Sinus Problems
❑ Low Back Pain	❑ Poor Immune System
❑ Hip / Knee Problems	❑ Become Stressed Easily
❑ Shoulder / Elbow / Arm Problems	❑ Mood Swings
❑ Digestive Problems	❑ Decreased Energy
❑ Other_____	❑ Arthritis

- Which of These Problems is the Worst? : _____
- How Long Have You Had This Problem?_____
- On a scale from one to ten (1 = No Pain and 10 = Severe Pain),
    - Where would you rate your problem?_____
- Are you currently seeing a Chiropractor? ❑Yes ❑No
    - If YES, when was last visit_____?

Check any health topics you are interested in:

- ❑ **Massage of the Month Club**
  (Repeat massage specials)
- ❑ **Weight Loss / Detoxification Programs**
  (Lose 7-10 lbs in 21 days)
- ❑ **Chiropractic Care**
  (Natural Pain Relief)
- ❑ **Heavy Metal Testing**
  (Is a toxin is poisoning you?)
- ❑ **Nutritional Counseling**
  (Supplements for your specific needs)
- ❑ **Custom Fit Shoe Orthotics**
  (Decrease foot, hip or knee pain)
- ❑ **FREE Health and Wellness Workshops**
  (Tuesdays at 6pm)
- ❑ **Low Level Laser Therapy**
  (Pain relieving and FDA approved)
- ❑ **Balancing Women's Hormones Naturally**
  (Reduce hot flashes, sleep better)
- ❑ Other _____

Informed Consent: The above statements are accurate to the best of my knowledge and I freely give my permission to be massaged. I agree to inform the therapist of any experience of pain during the session. I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so. Please note for all future appointments a 24 hour cancellation notice is required or a $29 missed visit fee will apply.

Client Signature:_____ Date_____

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