MASSAGE THERAPY INTAKE FORM – CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Client Name: _____ Date: _____

Date Of Birth: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Occupation: _____

Referred By: _____

Emergency Contact: _____

Have you ever received Massage Therapy/Bodywork before: _____

Type Of Massage/Bodywork Experienced (Swedish, Shiatsu, Deep Tissue, etc.): _____

What are your goals/expected outcomes for receiving Massage/Bodywork?

_____

_____

Do you have any sensitivities and/or allergies? (environmental, nuts, fragrances, skin care products, etc.): _____

If so, please give details: _____

Are you now under any Medical/Therapeutic treatment? _____

If so, please give details: _____

List the medications you currently take: _____

Injuries/Accidents/Illnesses still affecting you: _____

Surgeries and dates: _____

Are you wearing contact lenses?	☐ **Yes**	☐ **No**
Are you wearing dentures?	☐ Yes	☐ No
Are you wearing a hearing aid?	☐ Yes	☐ No
Are you wearing a hairpiece?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No

Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

Circle any of the following health conditions that you currently have (if you are unsure, lease ask). Please answer honestly, as massage may not be indicated for some conditions, or may have to be adjusted to suit you.

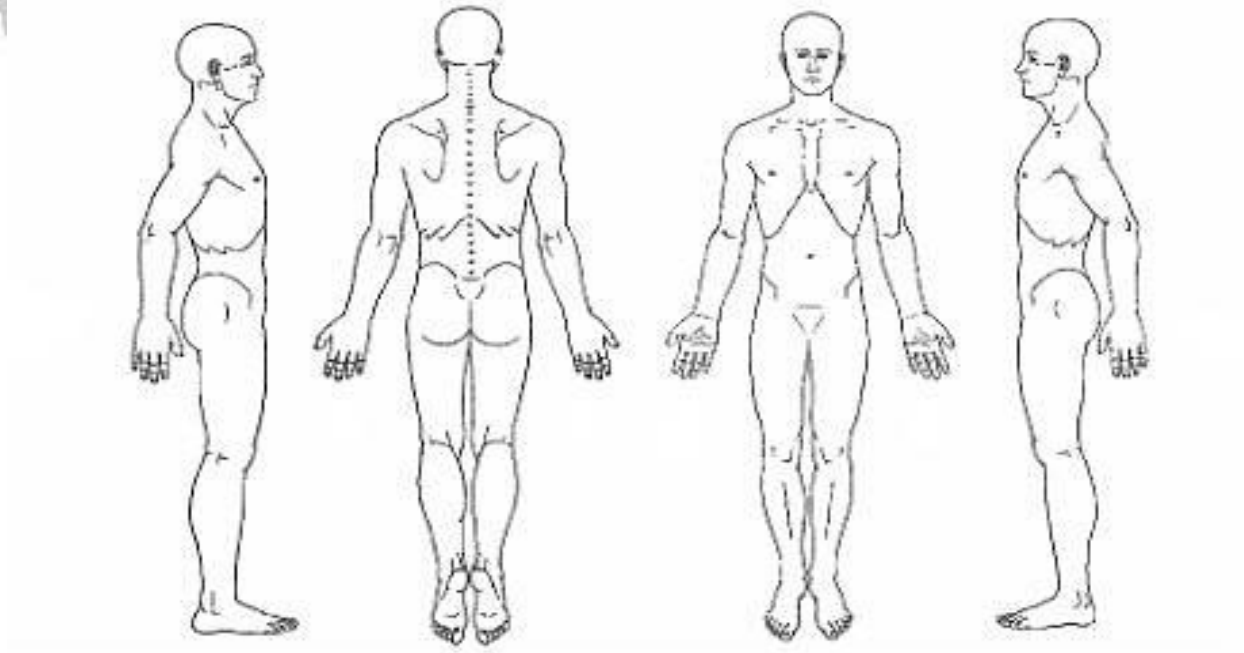
Muscle or joint pain	Current	Past
Muscle or joint stiffness	Current	Past
Numbness or tingling	Current	Past
Swelling	Current	Past
Bruise easily	Current	Past
Sensitive to touch/pressure	Current	Past
High/Low blood pressure	Current	Past
Stroke, heart attack	Current	Past
Varicose veins	Current	Past
Shortness of breath, asthma	Current	Past
Cancer	Current	Past
Neurological (e.g. MS, Parkinson's, chronic pain)	Current	Past
Epilepsy, seizures	Current	Past
Headaches, Migraines	Current	Past
Dizziness, ringing in the ears	Current	Past
Digestive conditions (e.g. Crohn's, IBS)	Current	Past
Gas, bloating, constipation	Current	Past
Kidney disease, infection	Current	Past
Arthritis (rheumatoid, osteoarthritis)	Current	Past
Osteoporosis, degenerative spine/disk	Current	Past
Scoliosis	Current	Past

Broken bones	Current	Past
Allergies	Current	Past
Diabetes	Current	Past
Endocrine/thyroid conditions	Current	Past
Depression, anxiety	Current	Past
Memory loss, confusion, easily overwhelmed	Current	Past

If any of the above needs to be detailed, or if there is anything else to share, please do so here:

_____
_____
_____
_____
_____
_____

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



CONSENT FOR TREATMENT

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/bodywork 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 of which I am aware. I understand that massage/bodywork practitioners 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/bodywork 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 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 advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I have read the therapist's policies; I understand them and agree to abide by them. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____