Massage Therapy Intake Form
CONFIDENTIAL INFORMATION

Today's Date _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (work/cell) _____ email _____

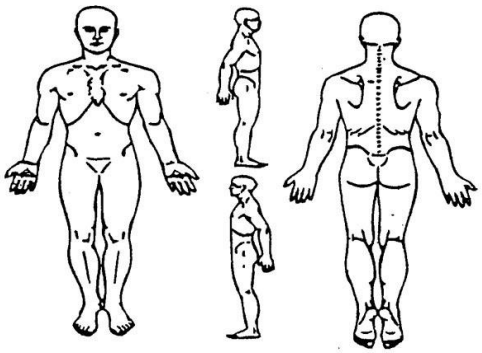
Occupation _____ Height _____ Weight _____

Emergency contact name & number _____

Referred by: _____

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below _____

_____



Describe any chronic pain/tension _____

What makes it better? _____

What makes it worse? _____

Are you currently under the care of a physician, chiropractor or alternative medicine practitioner? If yes, what are you being treated for? _____

Please list any medications (prescription or non-prescription), vitamins and supplements you are currently taking: _____

Are you currently receiving any other body or energy therapies? _____

If yes, what for? _____

What specific areas would you like for me to focus on or stay away from? _____

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Are there any areas you do NOT like massaged (i.e. feet, stomach, head, face)?_____

What do you hope to accomplish with this massage? (i.e. relaxation, decrease back pain, increase flexibility, etc.) _____

How frequently and for how long do you exercise and what do you do? Include sports, Pilates, yoga, gardening and/or other physical activities:_____

_____

How many hours of sleep do you receive each night (approximately)?_____
What is your sleeping position?_____
Check one: Are you right-handed ☐ or left-handed ☐
What is your daily intake of: Water: _____ Caffeine:_____Alcohol: _____

Please check any of the following that apply to you in the past or present::

Condition/Complaint	Past	Present	Condition/Complaint	Past	Present
Headaches Type:			**Pins and Needles in arms, legs, Hands or feet**		
Asthma			**Neurological problems**		
Cold Hands/feet			**Spinal Problems**		
Swollen ankles			**Herniated/Bulging Discs**		
Sinus Conditions			**Osteoarthritis**		
Frequent Colds			**Arthritis**		
Allergies (specify above)			**Anxiety**		
Loss of smell/taste			**Depression/Panic**		
Skin Conditions			**Sleep Disturbance**		
Painful/Swollen Joints			**Loss of Memory**		
Auto-immune disorder			**Whiplash**		
Cancer			**Bruise Easily**		
Varicose Veins			**Constipation/Diarrhea**		
Blood Clots/DVT			**Contact Lenses**		
Heart Problems			**Dentures/Partials**		
Pacemaker			**Hemorrhoids**		
High/Low BP			**Artificial/Missing limbs**		
Diabetes			**Muscular Tension**		
Epilepsy or Seizures			**Sciatica**		
Fainting Spells					

*Further explanation of any condition or other information:*_____

The following sometimes occurs during massage; they are normal responses to relaxation. Trust your body to express what it needs:

☯Need to move or change positions ☯Sighing, yawning, change in breath ☯Stomach gurgling
☯Emotional feelings and/or expressions ☯Movement of intestinal gas
☯Energy shifts ☯Falling asleep ☯ Memories

- I understand the treatment here is not a replacement for medical care.
- As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations
- I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.
- I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.
- I understand that payment is due at the time of treatment unless arrangements have been made otherwise.
- **I agree to give at least 24 hours notice of cancellation of appointment, otherwise will be expected to pay for session PLEASE INITIAL _____**

Client signature_____Date_____