
Massage Therapy Intake Form

CONFIDENTIAL INFORMATION

Today's Date _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

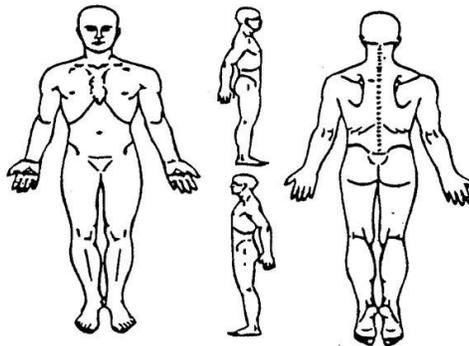
Phone (home) _____ (work/cell) _____ email _____

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 _____