

Massage 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.

Name _____ Date of Birth _____

Address _____ City _____

State _____ Zip Code _____ Home Phone _____ Cell _____

Email _____

First professional massage: Yes No; how frequently do you have massage? _____

Medical Information

List accidents/injuries, hospitalizations, and surgeries: when they occurred and treatment received

Any lingering effects from the above or do you feel you have recovered?

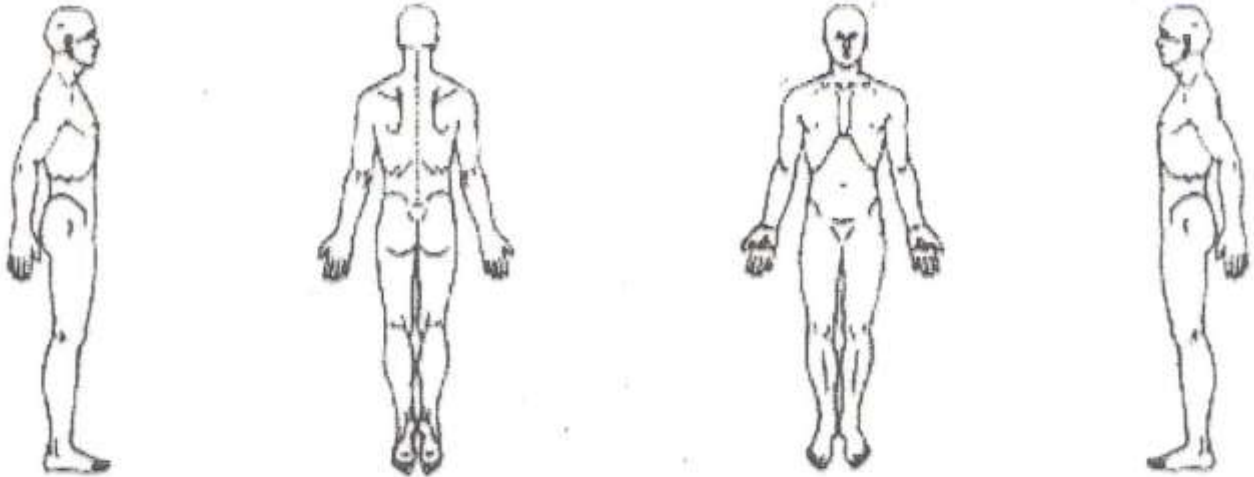
Chronic, ongoing pain? No Yes, please describe any care or treatment you receive

History

- | | | |
|--|--|--|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Athletes Foot | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Eczema/Dermatitis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Easily irritated skin | <input type="checkbox"/> Anxiety/Panic Attacks |
| <input type="checkbox"/> Whiplash | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bipolar syndrome |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Orthopedic pins or plates |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Stroke | <input type="checkbox"/> Implants |

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

On the following, please indicate the problem areas, if any, and the sensation: Pain, Numbness, Tingling, Stiffness, etc.



Currently are you experiencing any of the following conditions:

Cold or Flu Fever

Contagious Disease: _____

Infection: _____

Open Wounds/Sores: _____

Inflammation: _____

What are your goals/expectations for this therapy session?

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, it is not a substitute for medical examination, diagnosis, and treatment.
2. The information attained on the intake form is true to the best of my knowledge.
3. During future sessions, I agree to update the therapist on changes in my health status and medical history and understand that no liability on the therapist's part shall exist if I should neglect to do so.
4. I agree to inform the therapist of any experience of pain during initial and subsequent sessions.
5. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

Signature _____ Date _____