

massage

intake form

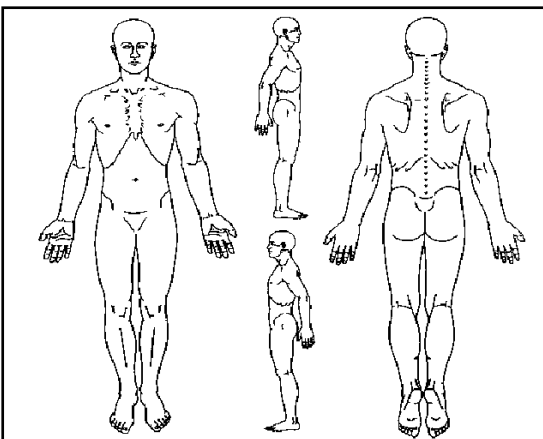


MESSAGE CLIENT INFORMATION FORM

Name:		Birth Date:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Occupation:	Email Address:	
Primary Care Physician:		Phone:
In case of an emergency, please contact:		Phone:
Who can we thank for referring you to our office: <input type="checkbox"/> Newspaper <input type="checkbox"/> Mail <input type="checkbox"/> Sign <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Referral _____ <input type="checkbox"/> Other _____		

MESSAGE HISTORY/SESSION INFORMATION

Have you ever received a professional massage? <input type="checkbox"/> Y <input type="checkbox"/> N		Date of last massage: / /
My goal for my massage session today is : <input type="checkbox"/> To relax <input type="checkbox"/> To help relieve a health concern <input type="checkbox"/> Other: <input type="checkbox"/> To get work on a specific area <input type="checkbox"/> To experience a therapeutic massage		List current medications and purpose:
Are you currently under the care of a health practitioner? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, specify purpose:		
I feel the pressure that would best fit my needs would be: <input type="checkbox"/> Very/light/light <input type="checkbox"/> Medium <input type="checkbox"/> Deep/Heavy <input type="checkbox"/> I don't know <i>*The therapist will always work within your tolerance level. It is your responsibility to tell him/her if the pressure is/isn't correct for you.</i>		



Please indicate any area of tension or soreness that you would like to massage therapist to address specifically.

Please circle or "X" the area to the left.

Prioritize ONLY specific problem areas:

- | | | |
|------------|------------------|-----------|
| ____ Neck | ____ Upper Back | ____ Hip |
| ____ Legs | ____ Lower Back | ____ Arms |
| ____ Hands | ____ Upper Chest | ____ Feet |
| | ____ Face/Scalp | |

(1-High Priority, 2-Secondary, 3- If we have time)

ABOUT YOUR HEALTH

The human body is designed to be healthy. At (Practice Name), we are dedicated toward achieving the goal of total lasting health for our members. To better help us achieve this, we need to understand your complete health history. Please help us help you by taking a few moments to answer the following questions.

PRESENT HEALTH CONDITIONS

Please mark any of the following that you now have or have had.

<p><u>Musculoskeletal</u></p> <input type="checkbox"/> Bone or joint disease <input type="checkbox"/> Tendonitis/Bursitis <input type="checkbox"/> Arthritis/Gout <input type="checkbox"/> Jaw Pain (TMJ) <input type="checkbox"/> Lupus <input type="checkbox"/> Spinal Problems <input type="checkbox"/> Other: _____	<p><u>Circulatory</u></p> <input type="checkbox"/> Heart Condition <input type="checkbox"/> Phlebitis/Varicose Veins <input type="checkbox"/> Blood Clots <input type="checkbox"/> High/Low Blood Pressure <input type="checkbox"/> Lymphedema <input type="checkbox"/> Thrombosis/Embolism <input type="checkbox"/> Other: _____	<p><u>Respiratory</u></p> <input type="checkbox"/> Breathing Difficulty/Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Allergies <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Other: _____
<p><u>Skin</u></p> <input type="checkbox"/> Allergies <input type="checkbox"/> Rashes <input type="checkbox"/> Athletes foot <input type="checkbox"/> Herpes/cold sores <input type="checkbox"/> Other: _____	<p><u>Nervous System</u></p> <input type="checkbox"/> Shingles <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Pinched Nerve <input type="checkbox"/> Other: _____	<p><u>Other</u></p> <input type="checkbox"/> Cancer/Tumors <input type="checkbox"/> Bladder/Kidney ailment <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug/alcohol/caffeine/tobacco use <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Chronic pain <input type="checkbox"/> Sleep disorders <input type="checkbox"/> Migraines/Headaches <input type="checkbox"/> Anxiety/Stress Syndrome <input type="checkbox"/> Depression <input type="checkbox"/> Contact lenses (hard or soft)
<p><u>Digestive</u></p> <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Ulcers <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	<p><u>Reproductive</u></p> <input type="checkbox"/> Pregnant: Stage _____ <input type="checkbox"/> Ovarian/Menstrual Problems <input type="checkbox"/> Prostate <input type="checkbox"/> Other: _____	

INFORMED CONSENT

I, _____, (client) understand that massage therapy provided by, _____, (massage therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

I have received a copy of the therapist's policies, I understand them and agree to abide by them.

Client Signature

Date