Patient Intake Form- Therapeutic and Relaxing Massage

Personal Information: (Please print)

Name_____ Address: _____Apt#_____ Zip_____

Phone _____ Email _____ Date of Birth: ___/___/___

Type of Employment_____ Referred by_____

Emergency Contact_____ Phone_____

The following information will be used to help plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Have you had a professional massage before? _____ How often? _____

Do you have any difficulty lying on your front, back or side? Yes or NO

If yes, please explain _____

Are there any areas you do NOT like massaged? _____

_____.

Do you have sensitive skin? Yes or No

Medical History

In order to plan a massage session that is safe and effective I need some general information about your medical history.

Are you currently under medical supervision? Yes or No

If yes, Please explain _____

_____.

Name of Physician _____ Chiropractor _____

Injuries/accidents/illnesses still affecting you _____

_____.

Surgeries you have had and dates _____

_____.

Are you taking any medications/ supplements _____.

Have you ever had seizures? Yes or NO

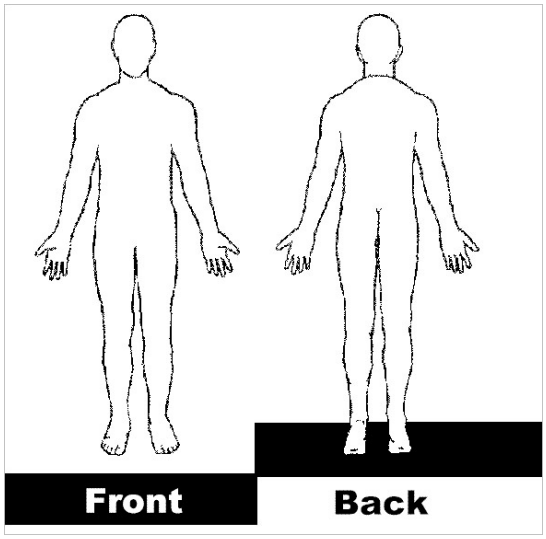
Have you ever been tested for a communicable disease? Yes or No What were the results?_____

_____.

Please Circle any condition listed below that applies to you:

Bone or joint disease	Heart condition	Rashes
Tendonitis/ Bursitis	Phlebitis/ Varicose Veins	Athletes foot
Arthritis/ Gout	Blood clots	Herpes/ Cold sores
Jaw pain (TMJ)	High/ Low blood pressure	Impetigo
Parkinson's Disease	Thrombosis/ Embolism	Psoriasis
Spinal problems	Asthma/ Emphysema	Cerebral Palsy
Diabetes	Depression	Pinched Nerve
Multiple Sclerosis	Migraines/ Headaches	HIV/ Aids
Numbness/ tingling	Irritable bowel syndrome	Ulcers
Bladder/ kidney ailment	Cancer/ tumors	Sleep disorder
Eating disorder	Prostate Ailment	Shingles/ Herpes
Osteoporosis	Current Fever	Tennis Elbow
Carpal Tunnel Syndrome	foot pain/ Plantar Fasciitis	Epilepsy
Whiplash	Pregnancy (month)_____	Flu/ Cold
Anxiety/ stress disorder	PMS/ menstrual problems	Scoliosis
Hepatitis	tuberculosis	Liver ailment
Mononucleosis	Fibromyalgia	Sciatic pain

<u>Please mark any areas of discomfort</u>



Other conditions not listed _____

_____

_____.

Please explain any condition you have marked or if you have any additional remarks/ comments:

_____
_____
_____
_____
_____
_____
_____
_____.

Draping will be used during the session-only the area being worked on will be uncovered. The massage is for therapeutic purposes only. No sexual innuendos or behavior will be tolerated.

10 minutes of the appointment will be needed for consultation and dressing.

I, _____ (Print name) understand that the massage I receive is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, and improve circulation. If I experience any pain of discomfort during the session, I will immediately inform the therapist so that the pressure and/ or strokes may be adjusted to my level of comfort. I further understand that the massage should not be construed as a substitute for medical examination, diagnosis or treatment and I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustment, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the session should be construed as such. Because massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part if I fail to do so.

Signature of Patient _____Date _____