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_____

State_____ City_____ Home Phone _____

~~Work Phone~~ Email _____ Occupation _____

Have you ever received massage therapy? _____ Yes _____ No

Type of massage experienced (swedish, shiatsu, deep tissue, etc.)_____

Are you currently taking any medications? _____ Yes _____ No

If yes, please list name and reason for medications_____

_____

_____

Are you currently seeing a healthcare professional? _____ Yes _____ No

If yes, please list names and reason/treatment_____

_____

_____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

___arthritis
___diabetes
___blood clots
___broken/dislocated bones
___bruise easily
___cancer
___chronic pain
___constipation/diarrhea
___auto-immune condition*
___hepatitis (A, B, C, other)
___skin conditions
___stroke
___surgery
___TMJ disorder
___depression, panic disorder, other psych condition
___diverticulitis
___headaches
___heart conditions
___back problems
___high blood pressure
___insomnia
___muscle strain/sprain
___pregnancy
___scoliosis
___seizures
___whiplash
___chemical dependency (alcohol, drugs)

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

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

please do so:_____

_____

Do you have any of the following today:

_____ skin rash _____ cold/flu _____ open cuts _____ severe pain

_____ anything contagious _____ injuries/bruises

Do you have any allergies to:

_____ medications _____ foods (nuts, etc.)

_____ environmental allergens (dust, pollen, fragrances)

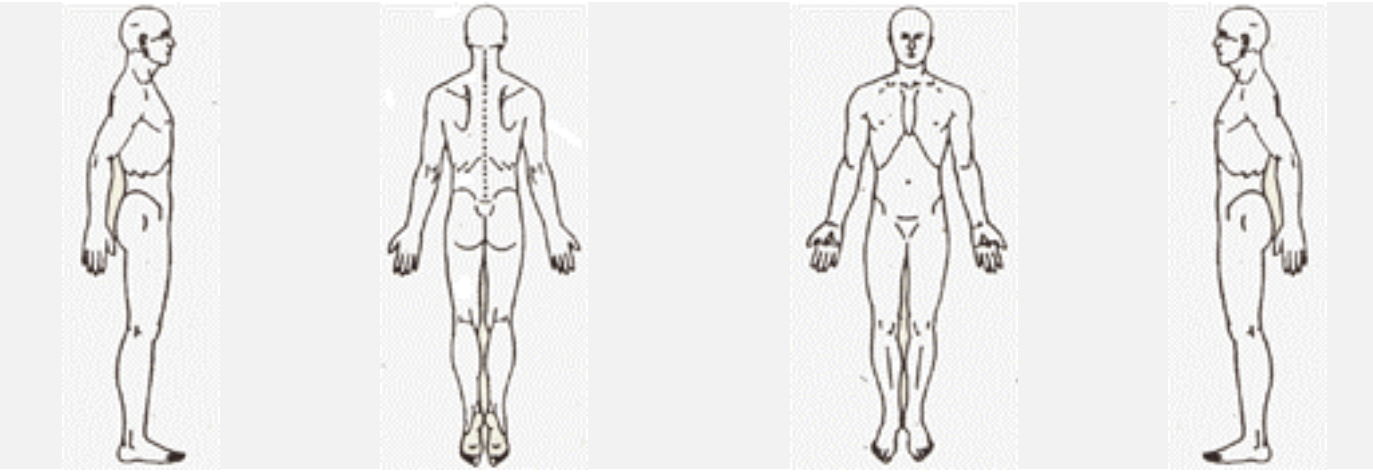
_____ reactions to skin care products

If any of the above are checked, please give details: _____

_____

Are you wearing: _____contact lenses _____ hearing aid _____ hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session?_____

_____

_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:
need to move or change position ❖ sighing, yawning, change in breathing
stomach gurgling ❖ emotional feelings and/or expression
movement of intestinal gas ❖ energy shifts ❖ falling asleep ❖ memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. 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.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature:_____Date_____