Massage Therapy Intake Form

Name: ____ Date of Birth: _______________
Home Phone: (____)________________________ Work Phone: (____)________________________
Email Address: ____
Address: ____ City: ____________ St: ____ Zip: ________
Referred By: ___________________________ Have you ever had professional massage before? ______
If so, how often? _______________ Do you exercise? ________________ Frequency: ______________
What type of exercise? ____
Other daily activities: ______________________________________ Occupation: _________________
Primary Care Physician: ________________________________ Chiropractor: ____________________
How do you relieve stress or pain? ____
What are the reasons for your visit today? ____
____
What are your other health concerns? ____
____
Describe any surgeries you have had: ____
____
Describe any accidents you have had: ____
____
List all conditions currently monitored by a Health Care Provider: ________________________________
____
List any medication that you took today: ____

Please note all current and previous conditions:

Headache	Y	N	Stiff/Painful joints	Y	N
Sleep problems	Y	N	Neck/shoulder/arm pain/numbness	Y	N
Fatigue	Y	N	Low back/hip/leg pain/numbness	Y	N
Flu/Cold symptoms in last 48 hrs	Y	N	Sciatica	Y	N
Sinus	Y	N	Depression	Y	N
Allergies to scents/lotions	Y	N	Blood clots	Y	N
Allergies, in general	Y	N	Stroke	Y	N
Arthritis	Y	N	Heart disease	Y	N
Osteoporosis	Y	N	High/Low blood pressure	Y	N
Scoliosis	Y	N	Poor circulation	Y	N
Broken bones	Y	N	Asthma	Y	N
Disc problems	Y	N	Thyroid dysfunction	Y	N
Spasms/Cramps	Y	N	Diabetes	Y	N
TMJ (Jaw pain)	Y	N	Currently pregnant/Breast feeding	Y	N
Tendonitis/Bursitis	Y	N	Malignant cancer/tumors	Y	N
Spinal problems	Y	N	Benign cancer/tumors	Y	N
Varicose veins	Y	N	Other:		

Describe, as needed, any conditions above, or other conditions you feel may be important**:** _____________
____
____

CONTINUE TO OTHER SIDE →→

CONTRACT FOR CARE:

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my massage therapist and other members of my healthcare team. I agree to participate in the self-care program that we select. I promise to inform my health care team any time I feel my well-being us threatened or compromised. I expect my Massage Therapist to provide safe and effective treatment.

CONSENT FOR CARE:

It is my choice to receive to receive massage therapy, and I give consent to receive treatment. I understand that Massage Therapists DO NOT diagnose illness, disease or any other physical or mental disorders. Massage therapy is not a substitute for medical examination and/or diagnosis. I affirm that I habe stated all my known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my physical/mental health. I also agree there shall be no liability on the practitioner's part, should I neglect to do so.

Signature: ____ Date: _____________________

Signature of parent/guardian: ______________________________ Date: _____________________
(if patient is a minor)