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 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)

TO BE INITIALED BY TREATING PRACTITIONER AFTER COMPLETED:
Health history risk factors have been reviewed with the patient by the practitioner, and patient has been given time to ask questions. The treatment plan was reviewed, as well as discussing any potentially sensitive areas that may need to be addressed in the process.
PRACTITIONER'S INIT _____