

**MASSAGE THERAPY INTAKE FORM**

**Please Print**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **SS#:** Insurance Only \_\_\_\_\_

\_\_\_\_\_ **TDL#:** \_\_\_\_\_

**Phone Home:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**Work:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Cell:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

In Case of Emergency-Notify: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may I thank for this referral? \_\_\_\_\_

What is your major concern today? \_\_\_\_\_

Other areas of concern? \_\_\_\_\_

Have you ever had a massage before? Yes No

Are you currently under the care of a health professional for any reason?

Yes No **Diagnosis?** \_\_\_\_\_

Please list previous injuries, including broken bones, NOT requiring surgery? \_\_\_\_\_

Previous surgeries with approximate dates: \_\_\_\_\_

Please **CIRCLE** any illness or medical conditions which apply:

- |           |                 |                  |                       |
|-----------|-----------------|------------------|-----------------------|
| Diabetes  | Headache        | Painful Joints   | Ruptured/Bulging Disc |
| Arthritis | Contact Lense   | Liver Disorders  | Elevated Cholesterol  |
| Seizures  | Heart Condition | Scoliosis        | High Blood Pressure   |
| Cancer    | Skin Disorders  | Depression       | Infectious Conditions |
| Stroke    | Varicose Veins  | Pins/Needles     | Autoimmune Disorder   |
| Phlebitis | Loss of Balance | Bruxing/Grinding | Previous MVA/Trauma   |

Other: \_\_\_\_\_

Medications: \_\_\_\_\_ Vitamins: \_\_\_\_\_ Herbs: \_\_\_\_\_ Muscle Relaxants: \_\_\_\_\_

Aspirin/Anti-Inflammatories: \_\_\_\_\_ Sleeping Aids: \_\_\_\_\_

Anti-Anxiety/Depressants: \_\_\_\_\_ Pain Reducers: \_\_\_\_\_

Other: \_\_\_\_\_

In which part(s) of your body do you feel stree most often? Check all that apply.

Head: \_\_\_\_\_ Neck: \_\_\_\_\_ Back: \_\_\_\_\_ Shoulders: \_\_\_\_\_

Extremities: \_\_\_\_\_ Digestive: \_\_\_\_\_ Other: \_\_\_\_\_

Are there any areas that you would specifically like to have worked on? \_\_\_\_\_

Any possibility that you are pregnant? \_\_\_\_\_

I have completed this form to the best of my knowledge. I will not hold the massage therapist responsible for injury due to any undisclosed illness or condition.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_