Confidential Intake Form

Date _____

Personal Data

Name_____ Date of Birth_____
(Please Print)

Address _____ Home Phone (___)_____
(Circle)

City/ State/Zip _____Cell or Work Phone (__)_____

Occupation _____ Referred By _____

Emergency contact person: _____ Phone (___)_____

Name of Physician: _____ Phone (___)_____

Permission to consult with your Physician? If Yes, Initial here _____

Email Address _____

Are you pregnant or trying to become pregnant? Yes / No *Number of months _____*

Medical History

Please check any that apply:

❑ AIDS	❑ Curvature of the back	❑ Osteoporosis
❑ Allergies	❑ Diabetes	❑ Numbness/Tingling
❑ Arm, Neck, Shoulder Pain	❑ Drug/Alcohol Addiction	❑ Panic Disorder
❑ Arthritis/ Bursitis	❑ Fatigue / Depression	❑ Physical /Emotional Abuse
❑ Asthma	❑ Fibromyalgia	❑ Pink Eye
❑ Athletes Foot	❑ Fractured/Broken Bones	❑ Respiratory/Lung Problems
❑ Blood clots / Bruises	❑ Fungus of the Nails	❑ Ruptured/bulging disc
❑ Blue Finger or Toe Nails	❑ Headache / Head Injuries	❑ Seizures
❑ Cancer / Tumors	❑ Heart Condition / Attack	❑ Sinus Problems
❑ Chronic Pain	❑ High or Low Blood Pressure	❑ Skin Conditions/rashes/ warts
❑ Claustrophobia	❑ Irritable Bowel/ Crohn's Disease	❑ Sleep Disorders
❑ Cold / Flu	❑ Jaw Pain / TMJ	❑ Stroke
❑ Constipation	❑ Kidney Disease/Infection	❑ Shingles / Herpes
❑ Cramps/ Spasms	❑ Low Back, Hip, Leg Pain	❑ swelling of ankles or feet
❑ Cold Sores	❑ Lymph Edema	❑ Varicose Veins
❑ Contact Lenses	❑ Muscular Conditions	❑ Whiplash

List any conditions that are not listed above: _____

List all medications - prescription or over the counter_____

_____

List Any Accidents or Surgeries and approximate dates _____

Self Help: What have you Tried or Are you doing to address the pain or problem?_____

_____

I realize that the massage therapy I will receive is not a substitute for medical treatment but an avenue to relax both mind and body. I agree to communicate with my therapist any time I experience discomfort or perceive my well-being as being compromised.

I have read and answered all the questions truthfully. It is my understanding that massage may not be advised for certain medical conditions. I have disclosed all known medical conditions on this form. I will update the massage therapist of any changes in my health status.

The massage received by me will be a nonsexual massage. To preserve modesty, the genital area will be draped at all times. If I am a female, the breast area will also be draped during the session.

Any breach of conduct will cause immediate terminate of the session.

Signature: _____ Date: _____ Therapist Initials: _____

Have you ever received a professional massage before? YES / NO

What results do you expect from this session? _____

Please circle the areas of your body that you give permission to receive massage:

Scalp Face Neck Arms Chest Abdomen Back Buttocks Legs Feet

Mark the areas of the body where you feel any of these sensations. Please Use Symbols

Tightness X X X X Numbness ++++ Pins & Needles 0 0 0 0 Aching # # # #