

INITIAL INTAKE FORM FOR MASSAGE THERAPY

Last Name:	First:	Home Ph:	Date:
Street:	City:	State:	Zip:
D.O.B.	Occupation:	Work Ph:	
Referred by:		Primary Care Physician:	
Emergency Contact, Name:		Relationship:	Ph:
Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___			
Have you ever received a professional massage? Yes ___ No ___ How many times? ___			
Why did you come for our service? Relaxation ___ Pain ___ Neuromuscular Therapy ___			
What results would you like to achieve?			
Please prioritize the areas of your body that you wish to be massaged. Also indicate any areas of your body that you prefer not to be massaged.			
What is your major concern today?			
Do you have any physical discomfort(s)? Yes ___ No ___ Briefly describe:			
Type of Pain: None ___ Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting ___ Burning ___ Tingling ___ Cramping ___ Stiffness ___ Swelling ___ Other _____			
Intensity of Pain: Mild ___ Moderate ___ Severe ___ Other _____			
Frequency of Pain: Constant ___ Intermittent ___ Only with certain motions ___			
Duration of Pain: Minutes ___ Hours ___ Days ___			
When did you first notice this pain?			
What activities (if any) are difficult to perform?			
Are you currently under the care of a health practitioner for any reason? Yes ___ No ___ Briefly describe:			
Has there been a medical diagnosis? Yes ___ No ___ Describe:			
What are your most frequent activities involved in work or home? Standing ___ Sitting ___ Lifting ___ Pulling ___ Pushing ___ Other ___ Describe:			
Do you exercise regularly? Yes ___ No ___ Frequency _____			
Healthy Diet? Always ___ Frequently ___ Sometimes ___ Infrequently ___ Rarely ___			
Adequate Sleep? Always ___ Frequently ___ Sometimes ___ Infrequently ___ Rarely ___			
Sleep Position? Back ___ Side ___ Stomach ___ Still ___ Restless, many positions ___			
Habits? Coffee/Tea ___ Sugar/Sodas, etc. ___ Tobacco ___ Alcohol ___			
In which part(s) of your body do you feel stress most often? (Check all that apply)			
Head ___ Neck ___ Shoulders ___ Back ___ Digestive ___ Extremities ___ Other _____			
Do you set aside a portion of your day for relaxation? Yes ___ No ___			
If yes, what type of relaxation?			

Previous Surgeries? Yes ___ No ___ *Please list any previous surgeries with dates:*

Previous Injuries (including broken bones)? Yes ___ No ___ *Please list any previous injuries:*

Please review this list and circle any illnesses and/or medical conditions that apply:

Blood clots	Stroke	Loss of balance	Previous MVA / trauma	Depression
Thyroid problems	Headache	Bruxing /grinding	Fatigue / depression	Bipolar disorder
Osteoporosis	Pins / needles	Jaw pain / TMG	Painful joints	Schizophrenia
Whiplash	Contact lenses	Ruptured / Bulging disc	Bursitis	Dementia
Diabetes	Skin disorder	Elevated Cholesterol	Tendonitis	Dissociative disorder
Arthritis	Varicose veins	Infectious conditions	Heart condition	Chemical dependency
Seizers	Phlebitis	Autoimmune disorder	High blood pressure	Eating disorder
Cancer	Scoliosis			

Please list any other illnesses or medical conditions:

Have you ever been physically or sexually abused? Yes ___ No ___

Are you currently taking any prescription **OR** over-the-counter medications?

Yes ___ No ___

Check those that apply: Vitamins ___ Herbs ___ Aspirin/Anti-inflammatory ___
Muscle Relaxants ___ Pain Reducers ___ Anti-anxiety/Depressants ___ Sleeping Pills ___

Are you pregnant? Yes ___ No ___ Due Date:

Do you have any other questions or comments for your massage therapist?

CONSENT FOR THERAPY

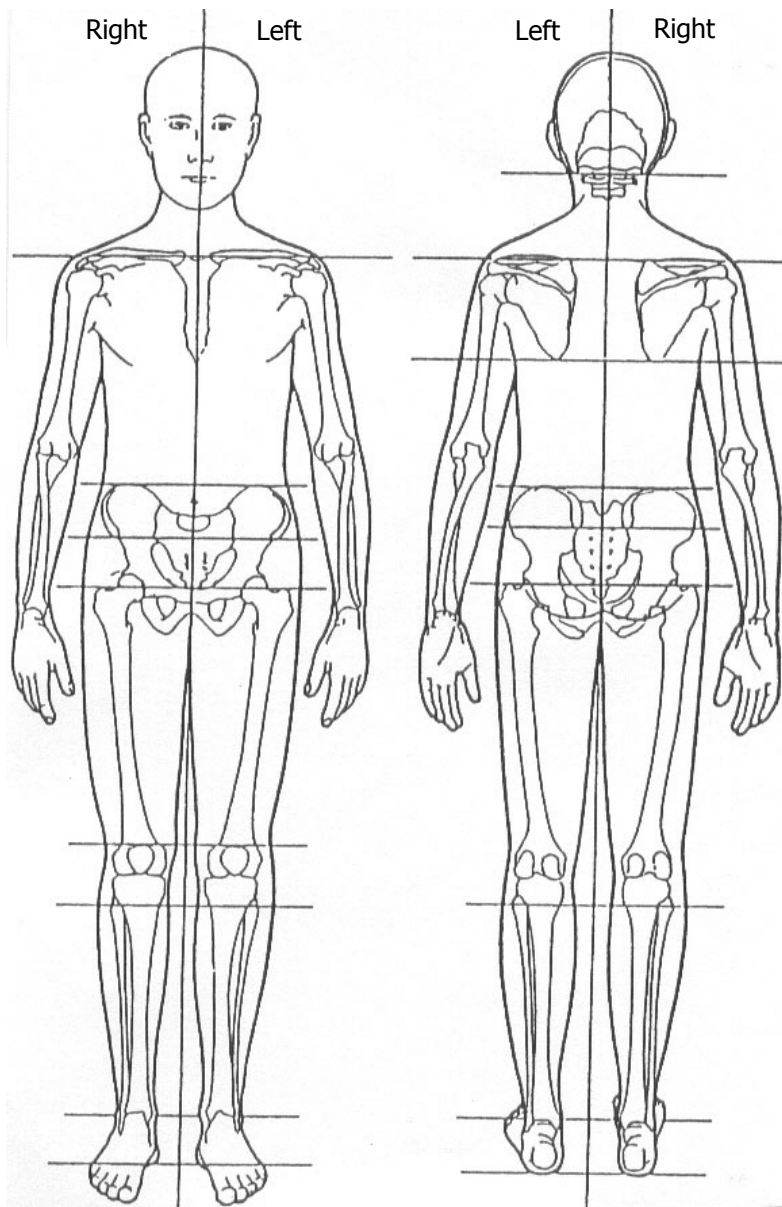
- The unclothed body will be properly draped at all times for your warmth, sense of security, and as a mark of massage professionalism.
- Focused attention and manual therapy will be given as agreed upon by therapist and client for the predetermined goals of stress reduction, relief of muscular discomfort, and/or health promotion. My therapist has discussed the potential benefits and possible side effects of this therapy. I have been given an opportunity to ask questions.
- I as client agree to provide complete and accurate health information and notice of health changes at successive appointments as appropriate.
- I understand that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment.
- Written referral is requested from your primary care provider if:
 - 1) you are currently receiving care, or
 - 2) you have a specific medical condition or symptoms for which you take medication or receive periodic evaluation or treatment.
- I will immediately inform my therapist of any unusual sensation or discomfort, so that the application of pressure or strokes may be adjusted to my level of comfort.
- I understand that this professional massage is therapeutic in nature and is performed by a trained, state-licensed therapist.
- I understand that the massage is not sexually oriented in any way and that any illicit or suggestive remarks or behavior on my part will result in immediate termination of the session.
- I understand that by signing this form, I give my consent to receive the treatment discussed in this and all future sessions and agree that my presence at subsequent sessions shall be construed to be validation of this written consent.
- I have read this form and hereby freely give my permission to be massaged.

Signature _____ Date _____

***Please give at least a 24 hour notice if you are
unable to keep your appointment.
Thanks!***

"Your Body Map"

On the figures below, mark the area(s) where you are feeling discomfort.



Client's Name