# Massage Therapy Intake Form

Name:_____ Date of Birth:_____
Home Phone: ( )_____Work Phone: ( )_____Cell Phone: ( )_____
E-mail address:_____
Address:_____City:_____St:_____Zip:_____
Referred by:_____ Have you ever had a professional massage before?_____
If so, how often?_____ Do you exercise?_____ Frequency:_____
Please describe what type of excersice_____
Other daily activities:_____ Occupation:_____
Primary Care Physician:_____ Chiropractor:_____
How do you relieve stress or pain?_____

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| 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 medications 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, or arm pain or numbness | Y | N |
| Fatigue | Y | N | Low back, hip or leg pain or numbness | Y | N |
| Flu or cold symptoms in the last 48 hours | Y | N | Sciatica | Y | N |
| Sinus | Y | N | Depression | Y | N |
| Allergies to scents or lotions | Y | N | Blood clots | Y | N |
| Allergies, in gereral | 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 | Y | N |
| Tendonitis/bursitis | Y | N | Malignant cancer or tumors | Y | N |
| Spinal Problems | Y | N | Benign cancer or tumors | Y | N |
| Varicose Veins | Y | N | | | |
| Describe, as needed, any conditions indicated above, or other conditions that you feel may be important | | | | | |

**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 health care 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 is 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 have 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)

**If you are unable to keep your appointment, please give 24 hours notice.**