MASSAGE THERAPY INTAKE FORM

Date: _____

Name: _____ Soc. Sec. #:_____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Occupation: _____ Employer: _____
Date of Birth: _____ Marital Status: □ Single □ Married □ Partnered
Children's Names and Ages: _____
Name of Spouse/Significant Other: _____
Preferred Appointment Day and Time: _____
Referred by: Patient or Dr.: _____ □Yellow Pages □Ad □Sign/Location
Method of Payment: □ Cash/Check/Credit Insurance: □ Health
□Auto (date of injury _____) □ L&I (date of injury_____)
What are your goals for treatment? _____
_____

Present Symptoms: What is your major complaint or condition you want to improve? _____
_____

What activities have you used to address this condition? _____
_____

What activities aggravate the condition? _____
_____

What activities improve the condition? _____
_____

Are you under medical/therapeutic treatment? □Yes □No
If yes, for what condition? _____
_____

Please list your care provider's name and number: _____

List any medications (including aspirin) and nutritional supplements you are taking: _____
_____

Specify any known allergies: _____
_____

Please list any additional comments regarding your general well-being: _____
_____

Please mark signs and symptoms below using the following symbols: O – occasional F – frequent C – constant
Leave blank if does not apply.

GENERAL SYMPTOMS
____headache
____chills
____fainting
____dizziness
____loss of sleep
____fatigue
____nervousness
____loss of weight

GASTRO-INTESTINAL
____poor appetite
____poor digestion
____nausea
____vomiting
____constipation
____diarrhea
____ulcers
____hemorrhoids

EAR, EYE, NOSE, THROAT
____ear ache
____ears ring/buzz
____blurred vision
____nose bleeds
____sore throat
____frequent colds
____sinus trouble

RESPIRATORY
____cough
____chest pain
____difficulty breathing

GENITO-URINARY
____frequent urination
____inability to control
____urinary infection
____blood in urine
____bed wetting
____prostate problem
____pain on urination

MUSCLE AND JOINTS
____stiff neck
____neck pain
____weakness or pain arms/hands/ legs/face (circle)
____numbness or pain arms/hands/ legs/face (circle)
____back pain: upper/lower
____swollen joints
____foot troubles
____pain between shoulders
____shoulder pain
____wrist pain/carpal tunnel
____elbow pain
____knee pain

CARDIO-VASCULAR
____high blood pressure
____low blood pressure
____strokes
____poor circulation
____swelling in ankles/legs

SKIN OR ALLERGIES
____rashes
____bruising easily
____dryness
____sensitive skin

HABITS
____smoking ____pks/day
____alcohol ____drinks/day
____coffee ____cups/day

EXERCISE
____none ____moderate
____daily

FOR FEMALES ONLY
____painful periods
____irregular cycles
____hot flashes
____cramps
Pregnant at this time: Yes No
Last menstrual cycle_____

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

____appendicitis
____pneumonia
____rheumatic fever
____polio
____tuberculosis
____whooping cough
____anemia
____measles
____mumps
____chicken pox
____diabetes
____asthma
____heart disease
____goiter
____influenza
____pleurisy
____alcoholism
____venereal disease
____arthritis
____epilepsy
____mental disorder
____stress (home)
____stress (work)
Other_____

ADDITIONAL COMMENTS:

_____

_____

Massage Therapy Informed Consent

I, _____, (client) understand that massage therapy provided by Jon Wall, Patrick Kendrick, Jennifer Jorgensen, Amber Taylor and/or Amy Dawson (massage therapists) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other purposes of massage specified below:

_____

_____

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

I have received a copy of the massage therapist's policies and I understand them and agree to abide by them.

Tipping the massage therapists is welcomed and appreciated, but by no means expected.

Client Signature: _____ Date: _____

Consent to Treatment of a minor: _____ Date: _____