INTAKE FORM

First Name:_____ Last Name:_____ Date:_____
Street Address:_____ City, State, Zip:_____
Daytime Phone #:_____ Date of Birth:_____
Email Address:_____Occupation:_____
Emergency Contact:_____
Relationship:_____ Phone #:_____
I would like to be added to the email list so I can find out about special deals:_____

The Following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Have you had a massage before?_____ How often?_____
What do you do for excercise?_____How oftern?_____
Do you smoke?_____
Please check any that apply to you

___Arthritis	___Bursitis	___Carpal Tunnel	___ Sciatica
___Nerve condition	___Migraines	___Dizziness	___Fatigue
___Insomnia	___Depression	___Kidney Issues	___Chronic Pain
___Muscle Stiffness	___Muscle Spasms	___Muscle Cramps	___Jaw Pain, TMJ
___Skin disorder	___Skin sensitivity	___Eczema or Psoriasis	___Scoliosis
___Bulging Disc	___Ruptured disc	___Numbness	___Kidney Condition
___Digestive Problems	___Irritable Bowel Syndrome		___ Constipation
___Ulcers	___Abdominal Pain	___Hernia	___Allergies
___Sinus problems	___Asthma	___Respiratory disease	___Contagious disease
___Cancer	___Hypoglycemia	___Diabetes	___Broken Bones
___Low/High Blood Pressure	___ Chest Pain	___Heart Disease	___Heart Arrhythmia
___Circulation Problems	___Blood clots	___Varicose veins/DVT	___Epilepsy

Are there any other conditions you want us to know about?_____
_____
_____
What medications are you currently taking?_____
Are there any other conditions or issues that you feel we need to know about?_____
_____
Are there any areas you don't want us to work on (abdomen, chest, face)?_____
_____

Please read and sign:

The medical history I have given is accurate and complete to the best of my knowledge. I will inform the massage therapist of any changes in my physical health prior to my next massage. Because massage may be contraindicated for specific medical conditions, I hereby release the massage therapist from any liability if I should intentionally or unintentionally omit information regarding any medical condition that I may have. I also understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder and nothing said in the course of treatment should be construed as such. As such, the therapist does not prescribe medical treatment, pharmaceuticals, nor performs spinal manipulations.

Signature:_____ Date:_____