

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 exercise? _____ How often? _____
Do you smoke? _____

Please check any that apply to you

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Nerve condition	<input type="checkbox"/> Migraines	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Issues	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Muscle Stiffness	<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Muscle Cramps	<input type="checkbox"/> Jaw Pain, TMJ
<input type="checkbox"/> Skin disorder	<input type="checkbox"/> Skin sensitivity	<input type="checkbox"/> Eczema or Psoriasis	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Bulging Disc	<input type="checkbox"/> Ruptured disc	<input type="checkbox"/> Numbness	<input type="checkbox"/> Kidney Condition
<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Irritable Bowel Syndrome		<input type="checkbox"/> Constipation
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Hernia	<input type="checkbox"/> Allergies
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Asthma	<input type="checkbox"/> Respiratory disease	<input type="checkbox"/> Contagious disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Low/High Blood Pressure	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Arrhythmia
<input type="checkbox"/> Circulation Problems	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Varicose veins/DVT	<input type="checkbox"/> 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: _____