



INTAKE FORM

First Name _____

Date of birth _____

Last Name _____

Referred by _____

Email Address _____

Mobile Phone # _____

Home Phone # _____

Work Phone # _____

Street Address _____

City _____

State _____

Zip Code _____

Emergency contact name _____

Physician's name _____

Emergency contact relationship _____

Physician's phone # _____

Emergency phone # _____

Date of initial visit _____

How would you rate your general health?

- Excellent
- Good
- Fair
- Poor

Have you had a professional massage before?

- Yes (Date of last treatment) _____
- No

List current medications & the conditions they are treating

List any major accidents or surgeries (including dates)

Please tell us about any allergies or hypersensitivities

Reason for initial visit

HEAD NECK

- Headaches / migraines
- Ringing in ears
- Vision problems
- Vertigo / dizziness
- Hearing loss
- Vision loss

RESPIRATORY

- Asthma
- Chronic cough
- Emphysema
- Frequent colds
- Family history of respiratory difficulties
- Shortness of breath
- Bronchitis
- Sinusitis
- Smoker

NERVOUS SYSTEM

- Sensory loss / change
- Sciatica
- Seizures
- Numbness / tingling
- Epilepsy
- Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- Arthritis
- Osteoporosis
- Bursitis
- Pins / plates / wires / artificial joint
- Family history of arthritis
- Tendonitis
- Jaw pain (TMJ)

REPRODUCTIVE

- Pregnant
- Gynecological problems
- Given birth

CARDIOVASCULAR

- High blood pressure
- Heart attack
- Heart disease
- Phlebitis / varicose veins
- Hemophilia
- Chronic congestive heart failure
- Family history of cardiovascular problems
- Low blood pressure
- Stroke
- Poor circulation
- Pacemaker

SKIN & INFECTIONS

- Hepatitis
- Herpes
- Lyme disease
- HIV / AIDS
- Tuberculosis
- Infectious skin conditions

OTHER CONDITIONS

- Cancer
- Unexplained weight loss
- Fibromyalgia
- Depression
- Psychiatric disorder
- Other conditions _____

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature: _____ Date: _____